AMENDATORY AGREEMENT

This **AMENDATORY AGREEMENT** is made between the **CITY AND COUNTY OF DENVER**, a municipal corporation of the State of Colorado (the "City") and V**IVENT HEALTH, INC**., a Wisconsin corporation with an address of 648 N. Plankinton Avenue, Suite 200, Milwaukee, Wisconsin 53203 (the "Contractor"), jointly ("the Parties").

RECITALS:

A. The Parties entered into an Agreement dated June 28, 2021, (the "Agreement") to perform the services set forth on Exhibit A, the Scope of Work, to the City's satisfaction.

B. The Parties wish to amend the Agreement to extend the term, increase the maximum contract amount, update standard provisions, and amend Exhibits A, B, E, F, G, H and I.

NOW THEREFORE, in consideration of the premises and the Parties' mutual covenants and obligations, the Parties agree as follows:

1. Section 2 of the Agreement entitled "**TERM**" is hereby deleted in its entirety and replaced with:

"**2**. **TERM:** The Agreement will commence on **March 1, 2021** and will expire on **February 28, 2023** (the "Term"). Subject to the Executive Director's prior written authorization, the Contractor shall complete any work in progress as of the expiration date, and the Term of the Agreement will extend until the work is completed or earlier terminated by the Executive Director."

2. Section 3 of the Agreement entitled "**COMPENSATION AND PAYMENT**" Sub-section A. entitled "**Fees and Expenses:**" is hereby deleted in its entirety and replaced with:

"**A. Fees and Expenses**: The City shall pay and the Contractor shall accept as the sole compensation for services rendered and costs incurred under the Agreement an amount not to exceed **SIX HUNDRED FORTY-ONE THOUSAND ONE HUNDRED TWENTY DOLLARS AND 00/100 ($641,120.00)** (the "**Maximum Contract Amount**") to be used in accordance with the budget contained in **Exhibit B**. Amounts billed may not exceed the budget set forth in **Exhibit B**. The Contractor certifies the budget line items in **Exhibit B** contain reasonable allowable direct costs and allocable indirect costs in accordance with 2 C.F.R., Subpart E."

3. Section 23 of the Agreement entitled "**NO EMPLOYMENT OF ILLEGAL ALIENS TO PERFORM WORK UNDER THE AGREEMENT:**" is hereby deleted in its entirety and replaced with:

"**23. NO EMPLOYMENT OF WORKERS WITHOUT AUTHORIZATION TO PERFORM WORK UNDER THE AGREEMENT:**

A. This Agreement is subject to Division 5 of Article IV of Chapter 20 of the Denver Revised Municipal Code, and any amendments (the "Certification Ordinance").

B. The Contractor certifies that:

(1) At the time of its execution of this Agreement, it does not knowingly employ or contract with a worker without authorization who will perform work under this Agreement, nor will it knowingly employ or contract with a worker without authorization to perform work under this Agreement in the future.

(2) It will participate in the E-Verify Program, as defined in § 8-17.5-101(3.7), C.R.S., and confirm the employment eligibility of all employees who are newly hired for employment to perform work under this Agreement.

(3) It will not enter into a contract with a subconsultant or subcontractor that fails to certify to the Contractor that it shall not knowingly employ or contract with a worker without authorization to perform work under this Agreement.

(4) It is prohibited from using the E-Verify Program procedures to undertake pre-employment screening of job applicants while performing its obligations under this Agreement, and it is required to comply with any and all federal requirements related to use of the E-Verify Program including, by way of example, all program requirements related to employee notification and preservation of employee rights.

(5) If it obtains actual knowledge that a subconsultant or subcontractor performing work under this Agreement knowingly employs or contracts with a worker without authorization, it will notify such subconsultant or subcontractor and the City within three (3) days. The Contractor shall also terminate such subconsultant or subcontractor if within three (3) days after such notice the subconsultant or subcontractor does not stop employing or contracting with the worker without authorization, unless during the three-day period the subconsultant or subcontractor provides information to establish that the subconsultant or subcontractor has not knowingly employed or contracted with a worker without authorization.

(6) It will comply with a reasonable request made in the course of an investigation by the Colorado Department of Labor and Employment under authority of § 8-17.5-102(5), C.R.S., or the City Auditor, under authority of D.R.M.C. 20-90.3.

C. The Contractor is liable for any violations as provided in the Certification Ordinance. If the Contractor violates any provision of this section or the Certification Ordinance, the City may terminate this Agreement for a breach of the Agreement. If this Agreement is so terminated, the Contractor shall be liable for actual and consequential damages to the City. Any termination of a contract due to a violation of this section or the Certification Ordinance may also,

at the discretion of the City, constitute grounds for disqualifying the Contractor from submitting bids or proposals for future contracts with the City."

4. Section 24 of the Agreement entitled "**NO DISCRIMINATION IN EMPLOYMENT**" is hereby deleted in its entirety and replaced with:

"**24. NO DISCRIMINATION IN EMPLOYMENT:** In connection with the performance of work under the Agreement, the Contractor may not refuse to hire, discharge, promote, demote, or discriminate in matters of compensation against any person otherwise qualified, solely because of race, color, religion, national origin, ethnicity, citizenship, immigration status, gender, age, sexual orientation, gender identity, gender expression, marital status, source of income, military status, protective hairstyle, or disability. The Contractor shall insert the foregoing provision in all subcontracts."

5. **Exhibit A** is hereby deleted in its entirety and replaced with **Exhibit A-1 Scope of Work**, attached and incorporated by reference herein. All references in the original Agreement to **Exhibit A** are changed to **Exhibit A-1**.

6. **Exhibit B** is hereby deleted in its entirety and replaced with **Exhibit B-1 Budget**, attached and incorporated by reference herein. All references in the original Agreement to **Exhibit B** are changed to **Exhibit B-1.**

7. **Exhibit E** is hereby deleted in its entirety and replaced with **Exhibit E-1, Subrecipient Financial Administration** attached and incorporated by reference herein. All references in the original Agreement to **Exhibit E** are changed to **Exhibit E-1**.

8. **Exhibit F** is hereby deleted in its entirety and replaced with **Exhibit F-1, Service Standards** attached and incorporated by reference herein. All references in the original Agreement to **Exhibit F** are changed to **Exhibit F-1**.

9. **Exhibit G** is hereby deleted in its entirety and replaced with **Exhibit G-1, Clinical Quality Management Plan Template** attached and incorporated by reference herein. All references in the original Agreement to **Exhibit G** are changed to **Exhibit G-1**.

10. **Exhibit H** is hereby deleted in its entirety and replaced with **Exhibit H-1, Clinical Quality Management Summary Template** attached and incorporated by reference herein. All references in the original Agreement to **Exhibit H** are changed to **Exhibit H-1.**

11. **Exhibit I** is hereby deleted in its entirety and replaced with **Exhibit I-1, Ryan White Plan Part A Self Attestation/No Change Form** attached and incorporated by reference herein. All references in the original Agreement to **Exhibit I** are changed to **Exhibit I-1.**

12. As herein amended, the Agreement is affirmed and ratified in each and every particular.

13. This Amendatory Agreement will not be effective or binding on the City until it has been fully executed by all required signatories of the City and County of Denver, and if required by Charter, approved by the City Council.

[THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK.]

Contract Control Number: ENVHL-202262519-01 / ENVHL-202158723-01
Contractor Name: Vivent Health, Inc.

IN WITNESS WHEREOF, the parties have set their hands and affixed their seals at Denver, Colorado as of:

SEAL

CITY AND COUNTY OF DENVER:

ATTEST:

By: _____

_____

APPROVED AS TO FORM:

Attorney for the City and County of Denver

By: _____

REGISTERED AND COUNTERSIGNED:

By: _____

By: _____

Contract Control Number: ENVHL-202262519-01 / ENVHL-202158723-01
Contractor Name: Vivent Health, Inc.

By: DocuSigned by: Tim Dyer F62C7A579ED14E3...

Name: Tim Dyer
(please print)

Title: Executive Vice President & CFO
(please print)

ATTEST: [if required]

By: _____

Name: _____
(please print)

Title: _____
(please print)

DENVER PUBLIC HEALTH & ENVIRONMENT

EXHIBIT A-1
SCOPE OF WORK

Purpose of Agreement

The purpose of this contract is to establish an agreement and Scope of Services between the Denver Department of Public Health & Environment (DDPHE), Denver HIV Resources (DHR) and **AIDS Resource Center of Wisconsin dba Vivent Health.**

AIDS Resource Center of Wisconsin dba Vivent Health has been awarded the following amounts in Ryan White Part A funds:

- Maximum of **$154,515.00** in Fiscal Year (FY) 2022 (March 1, 2022 – February 28, 2023)

II. Services and Conditions

A. The Denver Ryan White Part A HIV AIDS Program Service Standards are the minimum requirements that subrecipients are expected to meet when providing HIV care and support services funded by the Denver Ryan White HIV/AIDS Part A grant. All subrecipients **must** follow the Universal Standards in the Service Standards. Subrecipients are also responsible for meeting the standards outlined for each service category for which they receive funding. DHR evaluates program adherence to Service Standards during site visits. Subrecipients may exceed the requirements of the Service Standards, though this is not required and will not be evaluated during site visits. It is important that subrecipients are familiar with the Service Standards that apply to them. Denver HIV Resources Planning Council (DHRPC) initiatives and DHR programmatic updates may result in adjustments to the Service Standards during the Fiscal Year. DHR will inform subrecipients when changes are implemented and will provide subrecipients with an updated version of the Service Standards.

The Service Standards for fiscal year 2022 is attached as **Exhibit F**

B. AIDS Resource Center of Wisconsin dba Vivent Health is to provide the following services to individuals living with HIV/AIDS in the Denver Transitional Grant Area (TGA), which includes and is limited to, Adams, Arapahoe, Broomfield, Denver, Douglas, and Jefferson counties, in accordance with the Service Standards for the following service categories:

DENVER PUBLIC HEALTH & ENVIRONMENT

EXHIBIT A-1
SCOPE OF WORK

SERVICE CATEGORY	FUNDING SOURCE	FY 2022 AWARD AMOUNT
Case Management Continuum	RW Part A	$123,338.00
Early Intervention Services	RW Part A	$12,045.00
Food Bank and Home-Delivered Meals	RW Part A	$2,962.00
Mental Health Services	RW Part A	$3,453.00
Medical Transportation Services	RW Part A	$2,881.00
Outpatient Ambulatory Health Services	RW Part A	$5,955.00
Oral Health Care	RW Part A	$3,881.00

III. Process and Outcome Measures

AIDS Resource Center of Wisconsin dba Vivent Health will provide:

SERVICE CATEGORY	UNDUPLICATED CLIENTS	SERVICE UNITS DELIVERED
Case Management Continuum	129	1,455
Early Intervention Services	17	143
Food Bank and Home-Delivered Meals	80	211
Mental Health Services	9	75
Medical Transportation Services	34	784
Outpatient Ambulatory Health Services	32	107
Oral Health Care	40	315

IV. Clinical Quality Management Program

A. Clinical Quality Management Plan

1. Contractor will be required to submit an updated Clinical Quality Management Plan that is built on your FY 2021 plan. **Clinical Quality Management Plans will be due on May 27, 2022.** Quality Management Plans must follow the *Clinical Quality Management Plan Template* attached as **Exhibit G.**

2. Contractor will be required to submit two Clinical Quality Management Plan summaries for check-in. **The first summary is due on September 30, 2022 and the second summary is due on February 24, 2023.** The Clinical Quality Management Plan summaries must follow the *Clinical Quality Management Plan*

DENVER PUBLIC HEALTH & ENVIRONMENT

EXHIBIT A-1
SCOPE OF WORK

Summary Template attached as **Exhibit H.**

B. Clinical Quality Management Activities

1. Contractor will be required to document at least one quality improvement activity in the Fiscal Year

2. Quality Improvement activities should be related to the Clinical Quality Management Plan and impact the sub-recipients identified annual quality goals

3. Contractor will hold Clinical Quality Improvement focused meetings quarterly at a minimum.

V. Clinical Quality Management Infrastructure and Capacity Building

Contractor will be required to identify one contact person for all Quality Management related deliverables.

Contractor will be required to participate in two DHR hosted, Clinical Quality Management Trainings **dates TBD.**

VI. Case Management Continuum (CMC) Requirements

1. Contractors will be required to follow the CMC Service Standards **(Exhibit F)**

2. Contractors who are funded for case management services will also help clients apply for Emergency Financial Assistance, Housing Assistance, Oral Health Fund, and Legal Assistance Fund to clients.

3. Contractors who are funded for case management services will offer all four tiers of the Case Management Continuum (Medical Case Management, Non-Medical Case Management, Care Navigation, and Referral Services)

4. Contractors funded for CMC services will be required to report the number of clients served in each tier of service, as well as the number of service units. Reporting acuity of clients served will also be required. Contractors should begin taking steps to include acuity in their monthly data collection, however, the expectation is that this will not be fully implemented until September 30, 2022.

5. Any staff providing CMC services is required to complete the DHR provided, online, Case Management Certificate Program.

6. Contractors will be required to participate in all trainings related to the Case Management Continuum.

7. Contractors will be required to participate in the Trauma Informed Care trainings for Supervisors (3 part webinar series) and Trauma Informed Care for Leaders (3 part webinar series).

VII. Schedule of Payments for Services

A. Within 45 days of when the contract is executed, invoices for all service months completed before the execution date are due. Subsequent invoices shall follow the Contractor invoicing schedule outlined below:

B. Three or more occurrences of a late invoice shall be considered a contract compliance issue.

C. The Contractor is required to submit a complete invoice package monthly using required DDPHE HIV Resources invoice forms. A complete invoice package will include the following: a complete monthly invoice package for the service month and supporting documentation for all expenses.

VIII. Disallowances and Review of Reports

The City and County of Denver may review the budget, management, financial and audit reports, and any other materials or information the City and County of Denver may consider appropriate to assess whether any expenditures by the Contractor are disallowed by the City and County of Denver. **Exhibit E** attached as the Subrecipient Financial Administration describes expenditures that will be disallowed by The City and County of Denver. The City and County of Denver may disallow reimbursement for services or expenditures that were not provided or approved in accordance with the terms of this Agreement. The Contractor shall not unreasonably refuse to provide expenditure information related to this Agreement that the City and County of Denver may reasonably require.

These disallowances will be deducted from any payments due the Contractor, or if disallowed after contract termination, the Contractor shall remit the disallowed reimbursement to the City and County of Denver according to a schedule to be determined by the City and County of Denver at its sole discretion. Despite the City and County of Denver's

DENVER PUBLIC HEALTH & ENVIRONMENT

EXHIBIT A-1
SCOPE OF WORK

approval of expenditures, if a review or an audit conducted by the City, State or federal governments results in final disallowances of expenditures, the Contractor shall remit the amount of those disallowances to the City and County of Denver according to a schedule to be determined by the City and County of Denver at its sole discretion following written notice of disallowances to the Contractor. This Section survives termination or expiration of this Agreement.

IX. Administrative Cost Limit

The Contractor's total administrative costs cannot exceed **10%** of the maximum reimbursable amount. Administrative costs are defined as the costs incurred for usual and recognized overhead, including established indirect cost, management and oversight of specific programs funded under this contract and other types of program support such as quality assurance, quality control, and related activities. Examples of administrative costs include:

- Salaries and related fringe benefits for accounting, secretarial, and management staff, including those individuals who produce, review and sign monthly program and fiscal reports
- Consultants who perform administrative, non-service delivery functions
- General office supplies
- Travel costs for administrative and management staff
- General office printing and photocopying
- General liability insurance and
- Audit fees.

X. Invoices

Complete invoice packages are due to DDPHE HIV Resources at HIVInvoiceIntake@denvergov.org by the 15th calendar day of the second month following the month of service provision. Invoice requests for reimbursement of costs should be submitted on a regular and timely basis in accordance with policies established in the Subrecipient Financial Administration document attached as **Exhibit E**.

XI. Budget

Contractor shall submit a complete budget package using required DDPHE HIV Resources budget forms. The budget for this agreement is attached as **Exhibit B**.

XII. Budget Modifications

Contractor may submit budget modifications for review and approval based on policies established in the Subrecipient Financial Administration attached as **Exhibit E**. Approval of such request is based on the discretion of the Executive Director or his/her designee.

DENVER PUBLIC HEALTH & ENVIRONMENT

EXHIBIT A-1
SCOPE OF WORK

XIII. Performance Management and Reporting

A. Performance Management

Monitoring may be performed by the DDPHE HIV Resources staff. Contractor may be reviewed for:

1. **Clinical Quality Management Monitoring:** Review contractor Clinical Quality Management program inclusive of performance measures data, health outcomes, and satisfaction surveys.
2. **Program Monitoring*:** Review and analysis of current program information to determine the extent to which contractors are achieving established contractual goals.
3. **Fiscal Monitoring*:** Review financial systems and billings to ensure that contract funds are allocated and expended in accordance with the terms of the agreement.
4. **Program Income.** DDPHE requires subrecipients to report program income directly generated by a supported activity earned as a result of this grant on monthly invoices. Program income includes but is not limited to income from fees for services performed, e.g. direct payment or reimbursements received from Medicaid, Medicare, and third-party insurance. Program income does not include rebates, credits, discounts, and interest earned on any of these. See **Exhibit E** for further details.
5. **Administrative Monitoring*:** Monitoring to ensure that the requirements of the contract document, Federal, State and City and County regulations, and DDPHE policies are being met.
6. **Single Audit Report*:** If the contractor is required to complete the Single Audit (i.e. receive more than $750,000 per year in federal grants), then the contractor is required to submit the final Single Audit Report and the plan to respond to any findings to the DHR Section Manager.

*DDPHE HIV Resources *may provide regular performance monitoring and reporting.* DDPHE HIV Resources and/or its designee*, may manage any performance issues and may develop interventions that will resolve concerns.*

B. Reporting

The following reports shall be developed and delivered to the City as stated in this section.

DENVER PUBLIC HEALTH & ENVIRONMENT

EXHIBIT A-1
SCOPE OF WORK

Report # and Name	Description	Due Date	Reports to be sent to:
1). CAREWare Reporting	Contractor is required to enter client-level data monthly into CAREWare for all funded services including: 1. All client-level information required by HRSA: https://targethiv.org/sites/default/files/media/documents/2020-12/2020_RSR_Manual_Final_12_04_2020_508.pdf and/or requirements subject to change by HRSA 2. Contractor may enter client- level data into CAREWare using two different methodologies: Direct manual data entry via the CAREWare interface; or Provider Data Import (PDI).	Manual Data Entry Provider: 15th of each month PDI: 25th of each month	Into CAREWare system
2). Ryan White Part A Service Report (RSR)	Includes, but is not limited to: • Data input throughout the calendar year • Run provider RSR reports to clean existing data and/or input missing data with technical assistance from DHR • Review finalized RSR report with DHR • Generate client-level XML file and upload into the HRSA Web Application (per HRSA requirement) Submit RSR report into HRSA Web Application	TBD by HRSA, March 2023	Into CAREWare system for data entry Into HRSA Web Application for RSR final reporting
3).1st Quarter report	Report shall: • Review and verify the # of clients served, the number of service units, the amount of funding expended • Provide an update on changes to staff including vacancies and new staff	July 15, 2022	Data Administrator: Nick Roth Nicholas.roth@denvergov.org

DENVER PUBLIC HEALTH & ENVIRONMENT

EXHIBIT A-1
SCOPE OF WORK

4). 3rd Quarter Report	Report shall: • Review and verify the # of clients served, the number of service units, the amount of funding expended • Provide an update on changes to staff including vacancies and new staff	January 16, 2023	Data Administrator: Nick Roth Nicholas.roth@denvergov.org
6). Other reports, data or processes as reasonably requested by the City	To be determined (TBD)	TBD	TBD

XIV. CAREWare System Use

A. Contractor shall have active user access and system utilization of CAREWare application by agency staff.

B. Contractor shall manually enter new client eligibility data into CAREWare at their soonest opportunity, but at least weekly, to reduce barriers to care for newly enrolled Ryan White Part A clients, including uploading any/all eligibility documentation for said clients.

C. Contractor shall utilize Shared Eligibility data and State Drug Assistance Program (SDAP) surrogate data eligibility whenever said data is available in CAREWare to reduce barriers to care for Ryan White Part A clients.

D. Contractor shall utilize client referral features in CAREWare when said feature is implemented in CAREWare to reduce barriers to care for Ryan White Part A clients.

XV. Required Acknowledgement and Disclaimer Language

A. HRSA requires subrecipients to use the following acknowledgement and disclaimer on all products produced by HRSA grant funds:

"This [project/publication/program/website, etc.] [is/was] supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $XX with XX percentage financed with non-

governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov."

B. Subrecipients are required to use this language when issuing statements, press releases, requests for proposals, bid solicitations, and other HRSA supported publications and forums describing projects or programs funded in whole or in part with HRSA funding.

- Examples of HRSA supported publications include, but are not limited to, manuals, toolkits, resources guides, case studies, and issues briefs.

XVI. Other

Contractor shall submit updated documents which are directly related to the delivery of services.

EXHIBIT B-1 BUDGET

SUBRECIPIENT: Vivent Health

BUDGET CATEGORY	CMC-A	CMC-M	EIS-A	EIS-M	EFA	FBM	HS	LS	MHS-A	MHS-M
PERSONNEL + FRINGE	$ 108,125.50	$ -	$ 10,950.00	$ -	$ -	$ 2,692.80	$ -	$ -	$ 3,139.09	$ -
OPERATING COST	$ 4,000.00	$ -		$ -	$ -	$ -	$ -	$ -	$ -	$ -
OTHER		$ -		$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL DIRECT COST	$ 112,125.50	$ -	$ 10,950.00	$ -	$ -	$ 2,692.80	$ -	$ -	$ 3,139.09	$ -
INDIRECT COST	$ 11,212.50	$ -	$ 1,095.00	$ -	$ -	$ 269.20	$ -	$ -	$ 313.91	$ -
TOTAL BUDGETED COST	$ 123,338.00	$ -	$ 12,045.00	$ -	$ -	$ 2,962.00	$ -	$ -	$ 3,453.00	$ -

BUDGET CATEGORY	MTS	OAH	OHC	OHF	OPS	PSS-A	PSS-M	SAO-A	SAO-M	TOTAL
PERSONNEL + FRINGE	$ 2,119.00	$ 5,413.74	$ 3,528.20	$ -	$ -	$ -	$ -	$ -	$ -	$ 135,968.33
OPERATING COST	$ 500.10	$ -		$ -	$ -	$ -	$ -	$ -	$ -	$ 4,500.10
OTHER		$ -		$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL DIRECT COST	$ 2,619.10	$ 5,413.74	$ 3,528.20	$ -	$ -	$ -	$ -	$ -	$ -	$ 140,468.43
INDIRECT COST	$ 261.90	$ 541.26	$ 352.80	$ -	$ -	$ -	$ -	$ -	$ -	$ 14,046.57
TOTAL BUDGETED COST	$ 2,881.00	$ 5,955.00	$ 3,881.00	$ -	$ -	$ -	$ -	$ -	$ -	$ 154,515.00

Adjust to Award Letter Amount

EXHIBIT E-1

SUBRECIPIENT FINANCIAL ADMINISTRATION

SUBRECIPIENT FINANCIAL ADMINISTRATION

1.1 Invoice Policies

i. A complete Invoice package must be submitted monthly. Complete Invoice packages are due to Denver Department of Public Health and Environment (DDPHE) HIV Resources by the 15th calendar day of the second month following the month of service provision. For example, services provided in the month of March will be invoiced by May 15.

ii. The final complete Invoice package for the contract period is due no later than 45 days following the close of the contract period and must be clearly marked "Final Invoice". The City and County of Denver shall not be obligated to pay any invoice submitted after 45 days following the close of the contract period. For example, if the contract period ends February 28, the “Final Invoice” will be due by April 15.

iii. Invoices must only include amounts for actual direct costs expenditures.

iv. If underspending is anticipated, subrecipients must inform DDPHE HIV Resources immediately. DDPHE HIV Resources reserves the right to reallocate funds to expend all funding and to provide services at adequate levels.

v. Do not revise any previously submitted invoice. Make necessary adjustments on the next monthly invoice within the same contract year.

1.2 Supporting Documentation

i. Personnel – Include all salaries and allowances paid to staff directly contributing to the activities of the service category. Include documentation of staff time attributed to Ryan White Part A (for example, time sheets or time and effort reports). Additionally, include documentation verifying that payroll taxes have been paid (e.g. payroll report or payroll journal).

ii. Personnel Benefits – A schedule of benefits can be submitted once at the beginning of the fiscal year. Include documentation of personnel benefit costs with each invoice (for example, payroll journal or paystub).

iii. Consultants – Consultant invoice that reflects the job performed, rate, and hours.

iv. Contractual Expenses – Invoice that meets the payment arrangements specified in the agreement and that are properly approved.

v. Supplies/Equipment/Other Direct Costs – Copies of vendor invoices for all supply purchases or receipt(s). If sales tax is included on the invoice or receipt, demonstrate that the sales tax was not included in the invoice (for example, general ledger reports can be used show this).

vi. Travel – Supporting documentation will consist of properly approved invoices and should include airfare, ground transportation, accommodation, meals/per diem, etc. For airfare, economy class must always be used. International travel is never permitted.

1.3 Unallowable Costs

A. Below is a summary of unallowable costs; it is not intended to be a complete or definitive listing. Subrecipients are responsible for referring to the documents referenced below for complete guidelines.

i. Payment for any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to that item or service (a) under any state compensation program, under an insurance policy, or under any federal or state health benefits program; or (b) by an entity thatprovides health services on a prepaid basis [section 2605(a)(4)], consequently, program activities that are revenue generating may not be included in the budget.
ii. Funds may not be used to pay an individual's base salary in excess of $199,300
iii. Administrative costs that exceed 10% of your total budget [section 2604(e)]
iv. Purchase and/or improvement of land [section 2604(h)]
v. Purchase, construction, or permanent improvement of any building or other facility [section 2604(h)]
vi. Clinical trials [HRSA policy 97-02.3]
vii. Syringe exchange [section 2678 & HRSA letter 1/6/12]
viii. No cash incentives for clients are allowed. Gift card incentives are allowed – documentation must be kept of what the gift card is for (for example, King Soopers), who it is given to, by whom it was given, and which date it was distributed. Gift card incentives must not be used to purchase alcohol, tobacco, illegal drugs, or firearms.
ix. Costs associated with obtaining professional licensure or meeting program licensure requirements (e.g. Attorney Registration Fee, Notary Public License Fees, etc.) [HRSA policy notice 11 04]
x. Legal services for criminal defense, or class action suits unrelated to access to services eligible for funding [HRSA policy notice 10-02.11]
xi. Maintenance expense (tires, repairs, etc.) of a privately-owned vehicle or other costs associated with the vehicle, such as lease, or loan payment, insurance or license and registration fees [HRSA policy notice 10-02.12]

B. The following costs are <u>not permitted</u> under the Health and Human Services (HHS) Grants Policy Statement, HRSA National Monitoring Standards, Code of Federal Regulations 45 Part 75, and the Office of Management and Budget (OMB):

i. Local or state personal property taxes (residential property, private automobile, or any other personal property against which taxes may be levied)
ii. Cash payments to clients
iii. Cash payments to clients; funeral, burial, cremation and related expenses
iv. Staff training - service-specific capacity development dollars in excess of 5% of the dollars contracted to provide the service
v. Vocational, employment or employment-readiness services
vi. Clothing
vii. Pet foods or other non-essential products
viii. Household appliances
ix. Pre-exposure prophylaxis
x. Post-exposure prophylaxis
xi. Basic household items such as sheets, towels, blankets and kitchen utensils
Exceptions: kitchen cooking utensils allowable for Food Bank and Home-Delivered Meals Programs
xii. Off-premises recreational and social activities or payment for a client's gym
xiii. Non-targeted marketing promotions or advertising about HIV services that target the general public
xiv. Development of materials to promote or encourage injection drug use or sexual activity
xv. Outreach activities that have HIV prevention education as their exclusive focus
xvi. Bad debts
xvii. Capital improvements
xviii. Contingency provisions
xix. Contributions and/or donations to others
xx. Depreciation expenses as a direct cost and as related to federally funded equipment
xxi. Entertainment costs
xxii. Alcoholic beverages

xxiii. Selling and Marketing Costs
xxiv. Fines, penalties, damages and other settlements
xxv. Foreign travel
xxvi. Interest expense
xxvii. Lobbying costs
xxviii. Refreshments
xxix. Stipends
xxx. Taxes for which exemptions are available to the organization (including sales tax)
xxxi. Vehicles, without written Grants Management Officer approval

C. Health and Human Services (HHS) expressly prohibits client meals. HHS permits reasonable food costs associated with advisory board meetings as an administrative cost as follows:

- A modest meal or lunch costing no more than $13.50 per person; **or**
- Light refreshments consisting of breakfast or snack foods costing no more than $8.50 per person may be provided.

In all other instances, nutritious snacks (e.g. granola bars, fruit, etc.) of negligible value (no more than $3.50 per client) may be considered program supplies.

D. Limitation on Uses of Part A: The Contractor must adhere to a 10% limit on proportion of federal funds spent on administrative costs in any given grant year.

i. The Contractor shall prepare a project budget and track expenses, including administrative expenses, with sufficient detail. Expenditures are reported by line item within service category, with sufficient detail, and identify administrative expenses.

ii. The Contractor may use indirect costs as part or all their 10 percent administration costs. To do so, the Contractor must include indirect costs (capped at 10 percent) only where the DDPHE has a certified DHHS negotiated indirect cost rate using the Certification of Cost Allocation Plan or Certificate of Indirect Costs, which has been reviewed by the HRSA/HAB Project Officer. If the Contractor chooses to use indirect cost as part or all their 10 percent administration costs, they must obtain and keep on file a federally approved DHHS-negotiated Certificate of Cost Allocation Plan or Certificate of Indirect Costs. The contractor must submit a current copy of the certificate to DDPHE.

iii. The Contractor must ensure that budgets do not include unallowable costs. The Contractor will provide budgets and financial expense reports to DDPHE with sufficient detail to document that they do not include unallowable costs.

1.4 Budget Modification Requests

i. The Denver Department of Public Health and Environment (DDPHE) may, at its option, restrict the transfer of funds among line items, programs, functions, or activities at its discretion as deemed appropriate by the Executive Director or his/her designee.

ii. Minor modifications to the services provided by the Contractor or changes to each line item budget equal to or less than a ten percent (10%) threshold, which do not increase the total funding to the Contractor, will require notification to DDPHE program staff and upon approval may be submitted

with the next monthly draw. Minor modifications to the services provided by Contractor, or changes to each line item budget in excess of the ten percent (10%) threshold, which do not increase the total funding to Contractor, may be made only with prior written approval by the Executive Director or his/her designee. Such budget and service modifications will require submittal by Contractor of written justification and new budget documents. All other contract modifications will require an amendment to this Agreement executed in the same manner as the original Agreement.

iii. The Contractor understands that any budget modification requests under this Agreement must be submitted to DDPHE prior to the last Quarter of the Contract Period, unless waived in writing by the Executive Director or his/her designee.

1.5 Procurement

i. The Contractor shall follow the City Procurement Policy to the extent that it requires that at least three (3) documented quotations be secured for all purchases or services (including insurance) supplies, or other property that costs more than five thousand dollars ($5,000) in the aggregate.

ii. The Contractor will maintain records sufficient to detail the significant history of procurement. These records will include but are not limited to the following: rationale for the method of procurement, selection of contract type, contractor selection or rejection, and the basis for the contract price.

iii. If there is a residual inventory of unused supplies exceeding five thousand dollars ($5,000) in total aggregate upon termination or completion of award, and if the supplies are not needed for any other federally sponsored programs or projects the Contractor will compensate the awarding agency for its share.

1.6 Income from Fee-for-Services (Program Income)

Below are requirements from the HRSA National Monitoring Standards, Fiscal Requirements for Part A, Section C. Please reference this document for more detailed requirements.

i. The Contractor must document the use of Part A and third-party funds to maximize program income from third party sources and ensure that Ryan White is the payer of last resort. Third party funding sources include: Medicaid, Children's Health Insurance Programs, Medicare (including the Part D prescription drug benefit), and private insurance.

ii. The Contractor will document billing and collection from third party payers, including Medicare and Medicaid, so that payer of last resort requirements are met.

iii. If the Contractor receives funding in Medicaid eligible service categories, they will document participation in Medicaid and certification to receive Medicaid payments, unless waived by the Secretary of Health and Human Services.

iv. The Contractor must document retention of program income derived from Ryan White funded services and use of such funds in one or more of the following ways: funds added to resources committed to the project or program, and used to further eligible project or program objectives; and funds used to cover program costs.

v. On invoices, the Contractor will report all program income received the month of the invoice for all Ryan White Part A eligible clients for the following service categories: Outpatient/Ambulatory Health Services, Mental Health Services, Oral Health Care, and Substance Use Services – Outpatient. The

Contractor must also report how much program income was spent. Documentation of the program income received and how it was spent must be available upon request, which will typically occur at site visits. For more information on program income reporting policies, please reach out to Kathleen Risk at Kathleen.risk@denvergov.org.

1.7 Imposition & Assessment of Client Charges

Below are requirements from the HRSA National Monitoring Standards, Fiscal Requirements for Part A, Section D. Please reference this document for more detailed requirements.

i. The Contractor will have policies and procedures for a publicly posted schedule of charges (e.g. sliding fee scale) to clients for services, which may include a documented decision to impose only a nominal charge.

ii. The Contractor will not impose charges on clients with incomes below 100% Federal Poverty Level (FPL).

iii. Charges to clients with incomes greater than 100% of poverty are determined by the schedule of charges. Annual limitation on amounts of charge (i.e. caps on charges) for Ryan White services are based on the percent of client's annual income, as follows: 5% for clients with incomes between 100% and 200% of FPL; 7% for clients with incomes between 200% and 300% of FPL; and 10% for clients with incomes greater than 300% of FPL.

1.8 Fiscal Management

Below are requirements from the HRSA National Monitoring Standards, Fiscal Requirements for Part A, Section E and F. Please reference this document for more detailed requirements.

i. The Contractor must comply with all the established standards in the Code of Federal Regulations (CFR) for nonprofit organizations, hospitals, institutions of higher education, and state and local governments.

ii. The Contractor budgets and reports with sufficient detail to account for Ryan White funds by service category, subgrantee, administrative costs, and (75/25 rule) core medical and support services rules, and to delineate between multiple funding sources and show program income.

iii. The Contractor will submit a line-item budget with sufficient detail to permit review and assessment of proposed use of funds for the management and delivery of the proposed services. The budget should include at least four category columns; Administrative, Clinical Quality Management (CQM), HIV Services, Minority AIDS Initiative (MAI).

iv. The Contractor will document all request for approval of budget revisions.

v. The Contractor must track and report on tangible nonexpendable personal property, including exempt property, purchased directly with Ryan White Part A funds and having: a useful life of more than one year; and an acquisition cost of $5,000 or more per unit (lower limits may be established, consistent with DDPHE policies).

vi. The Contractor shall develop and maintain a current, complete, and accurate supply and medication inventory list and make the list available to DDPHE upon request. Title to supplies to be vested in DDPHE upon acquisition, with the provision that if there is a residual inventory of unused supplies exceeding $5,000 in total aggregate value upon termination or completion of the program, and the supplies are not needed for any other federally-sponsored program, DDPHE shall retain the supplies for use on non-federally sponsored activities or sell them and compensate the federal government forits share contributed to purchase of supplies.

1.9 Cost Principles

Below are requirements from the HRSA National Monitoring Standards, Fiscal Requirements for Part A, Section G. Please reference this document for more detailed requirements.

i. The Contractor will develop and maintain documentation that services are cost based. The Contractor will ensure that budgets and expenses conform to federal cost principles and that fiscal staff are familiar with applicable federal regulations.

ii. The Contractor must have written procedures for determining the reasonableness of costs, the process for allocations, and policies for allowable costs in accordance with provisions of applicable Federal cost principles and the terms and conditions of the award. Costs are reasonable when they do not exceed what would be incurred by a prudent person under circumstances prevailing at the time the decision was made to incur the costs.

iii. Requirements to be met in determining the unit cost of a service are: unit cost not to exceed the actual cost of providing the service, unit cost to include only expenses that are allowable under Ryan White requirements, and calculation of unit cost to use a formula of allowable administrative costs plus allowable program costs divided by number of units to be provided.

2.0 Matching or Cost Sharing Funds

Below are requirements from the HRSA National Monitoring Standards, Fiscal Requirements for Part A, Section I. Please reference this document for more detailed requirements.

i. If the Contractor provides matching or cost sharing funds, they must report these funds to DDPHE and meet the verification process to ensure that non-federal contributions: are verifiable in provider records; are not used as matching for another federal program; are necessary for program objectives and outcomes; are allowable; are not part of another federal award contribution (unless authorized); are part of the approved budget; are part of unrecovered indirect cost (if applicable); are apportioned in accordance with appropriate federal cost principles; include volunteer services, if used, are an integral and necessary part of the program, with volunteer time allocated value similar to amounts paid for similar work in the provider organization; value services of contractors at the employees' regular rate of pay plus reasonable, allowable and allocable fringe benefits; assign value to donated supplies that are reasonable and do not exceed the fair market value; value donated equipment, buildings, and land differently according to the purpose of the award; and value donated property in accordance with the usual accounting policies of the recipient (not to exceed fair market value).

2.1 Fiscal Procedures

Below are requirements from the HRSA National Monitoring Standards, Fiscal Requirements for Part A, Section K. Please reference this document for more detailed requirements.

i. The Contractor will have policies and procedures for handling revenues from the Ryan White grant, including program income. The Contractor will prepare a detailed chart of accounts and general ledger that provide for the tracking of Part A revenue and will make this available to DDPHE upon request.

ii. The Contractor has policies and procedures that allow DDPHE prompt and full access to financial, program, and management records and documents as needed for program and fiscal monitoring and oversight and will make this available to DDPHE upon request.

iii. The Contractor will grant access to payroll records, tax records, and invoices with supporting documentation to show that expenses were actually paid appropriately with Ryan White funds.

iv. The Contractor will provide timely, properly documented invoices to assist DDPHE to periodically track the accounts payable process from date of receipt of invoices to date the checks are deposited.

v. The Contractor will document employee time and effort, with charges for the salaries and wages of hourly employees. The Contractor will maintain payroll records for specified employees and will establish and consistently use allocation methodology for employee expenditures where employees are engaged in activities supported by several funding sources. The Contractor will make payroll records and allocation methodology available to DDPHE upon request.

vi. The Contractor's fiscal staff have responsibility to ensure adequate reporting, reconciliation, and tracking of program expenditures, coordinate fiscal activities with program activities (e.g., the program and fiscal staff's meeting schedule and how fiscal staff share information with program staff regarding contractor expenditures, formula and supplemental unobligated balances, and program income), and have an organizational and communications chart for the fiscal department.

EXHIBIT F-1

Part A Service Standards

Denver TGA Ryan White HIV/AIDS Program

Revised: March 2021 – December 2021

Finalized: 30 December 2021

Approved by the DHRPC: 06 January 2022

Table of Contents

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 assessment every 12 months.	**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 and only needs to be collected one time for eligibility purposes.
	A.2. Client must qualify as low income; a household income of less than or equal to 500 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 12 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 12 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 (with proof of residence in the Denver TGA)

		• 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 Denver TGA 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 business day, best practice being 1 business day.	**Program's Policies and Procedures** demonstrate process for responding to clients within 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	**Personnel File** demonstrates the type, amount (minutes or hours), and date of orientation and training that each staff receives both internally and externally.

	• 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.	
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.

I. Clinical Quality Management

Programs are responsible for ongoing clinical 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 other clinical quality management activities.	**Program's Reports** documents the use of a quality improvement system.
B. Each agency will have 1 quality plan (using the DHR Quality Plan Template) including all initiatives for required performance measures (core and support). If agency is also MAI funded a separate quality plan is permitted.	**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 clinical quality management activities, including at least one	**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.

quality improvement project focused on evaluating or improving HIV program services.	**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.

II. 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 to the release or exchange of any information.	**Client's File** contains a signed release of information form with all required elements appropriate to the services provided and information needed.
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**.**

III. 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	**A.1.** All staff members receive appropriate cultural mindfulness training within the first year of	**Program's Policies and Procedures** contain requirements for culturally

members effective, equitable, understandable, respectful and quality care that is provided in a manner compatible with the client's cultural beliefs, practices, and experience.	employment and at least annually thereafter. **A.2** Programs shall adopt and implement the National Standards for Culturally and Linguistically Appropriate Services (CLAS) as relevant to their program.	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.
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
		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.

	bilingual/bicultural interpreter.	
	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 by properly trained and certified staff.	**E.1.** Individuals providing interpretation services will have completed a medical interpreter training that includes: • Proficient interpretation skills; • Information on healthcare (and HIV care preferred); • Cultural mindfulness; and • Communication skills for advocacy.	**Personnel file** demonstrates the type, amount (minutes or hours), and date of training 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.

IV. 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 submitted to DHR with confidential information deducted as applicable.	**Program's Reports** document grievances.
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.

V. 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.
	B.3. Providers will have sliding scale fee that is consistent with state and federal guidelines, which include: • Sliding fee discount policy and schedule to ensure that clients with incomes below 100% of the FPL are not charged for services. • In the case of individuals with an income greater than 100% of the official poverty line and not exceeding 200% of the poverty line, service providers will not, for any calendar year, impose charges in an amount exceeding 5% of the annual gross income of the individual involved. • In the case of individuals with an income greater than 200% of the official poverty line and not exceeding 300% of the poverty line, service providers will not, for any calendar year, impose charges in an amount	Written sliding scale policy on file at provider agency. Providers will develop policy and procedures for a sliding scale fee that is consistent with state and federal guidelines including: • Publicly post the schedule of charges. • Develop and maintain a system for tracking client charges and payments. • Develop a process to alert the billing system that cap limits have been reached to ensure that charges are discontinued once the client has reached their annual cap.

	exceeding 7% of the annual gross income of the individual involved. • In the case of individuals with an income greater than 300% of the official poverty line, service providers will not, for any calendar year, impose charges in an amount exceeding 10% of the annual gross income of the individual involved. These limits shall apply only to agencies that impose any level of charges for services.	
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.

E. Program will make HIPAA-compliant virtual services available to all RWHAP Part A clients.	**E.1.** Program will ensure that clients have the option to receive services via HIPAA-compliant virtual platforms, if a service can be provided online.	**Program's policies and procedures** demonstrate that tele-health services are offered to clients, when applicable.
	E.2. Program will have procedures in place that give clients the right to accept tele-health services or deny tele-health services and request meeting with a provider in person.	**Program's policies and procedures** show that clients have a right to accept or deny tele-health services and to see a provider in person upon request.

VI. 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

Case Management Continuum

Case management is a multi-step process to ensure timely access to and coordination of medical and psychosocial services for a person living with HIV.

The goal of case management is to promote and support independence and self-sufficiency. As such, the case management process requires the consent and active participation of the client in decision-making, and supports a client's right to privacy, confidentiality, self-determination, dignity and respect, nondiscrimination, compassionate, non-judgmental care, a culturally mindful provider, and quality case management services.

DHR has adopted this case management structure from the Colorado Ryan White Part B Program. The case management continuum is a four-tiered approach to case management service that includes, medical case management (intensive medical needs) and non-medical case management (intensive psychosocial needs), care navigation (health education risk reduction), and referral for health care and support services. The medical and non-medical models of case management provide different levels of service geared to the needs and readiness of the client.

This case management continuum model may be provided in health care or social service settings, in large institutions or small community-based organizations.

Please note that throughout the document the word “provider” will be used to mean the person providing the case management service to clients. Because most of the providers consider themselves “case managers” this term will be used in the narrative portions of the service standards.

Medical Case Management is a proactive case management model intended to serve persons living with HIV with multiple complex medical and/or adherence health-related needs. The model is designed to serve individuals who may require assistance with access, utilization, retentionand adherence to primary health care services. Medical Case management clients need or want ongoing support from case management to actively engage in medical care, and continued adherence to treatment. Medical Case Management services focus on improving health care outcomes. Medical case management services offer a range of client-centered services that link clients with health care, psychosocial, and other services.

Non-Medical Case Management is a proactive case management model intended to serve people living with HIV with multiple complex psychosocial needs and their families/close support systems. The model is designed to serve individuals who may require or want ongoing case management support to stabilize their psychosocial needs. Non-medical case management is also an appropriate service for clients who have completed medical case management but still require or want a maintenance level of periodic support from a provider (case manager or case management team). Non-medical case management clients manage their care well enough to avoid chronic disruption to their medical care but require psychosocial support to maintain a stable lifestyle. Non-medical case management may also be provided to clients with multiple complex needs who may best be served by a medical case management program, but who are not ready or willing at this time to engage in the level of participation required by the medical case management model.

Care Navigation is intended to assist people living with HIV in accessing services and decision-making for their health-related and/or psychosocial needs. This model is designed to assist individuals whose needs are minimal and infrequent. It may also be used to provide services to those who do not want or are not ready to engage in more intensive case management services. Care Navigation strives to provide a varying level of support to a client’s need. When receiving Care Navigation services, the client may receive assistance in obtaining medical, social, community, legal, financial, and other needed services. However, Care Navigation does not involve coordination and follow-up of medical treatments, as medical case management does. Care Navigation also does not include the development and monitoring of a treatment plan.

Referral for Health Care and Support Services focuses on people living with HIV who were formerly engaged in more intensive tiers of case management and have progressed to self-management, or are only in need of Referral Services at this time. Referral Services assist clients to connect with needed core medical or support services and may be provided in person or through telephone, written, or other type of communication. Referral Services is intended to assess the sufficiency of self-management and to

provide additional services as indicated by the client. Referral Services clients may have low acuity or may have high acuity but do not want to engage in more intensive case management services at this time.

CORE ELEMENTS	***Medical Case Management***	***Non-Medical Case Management***	***Care Navigation***	***Referral***
Approach	***Proactive*** Need/Want for frequent support toaccess services	***Responsive*** Need/Want for episodic support toaccess services	***Responsive*** Need/Want for minimal support to access services	***Responsive*** Self-managed no support needed/wanted.
Brief Intake	Required	Required	Not Required.	Not Required.
Comprehensive Assessment	**Required at intake** **Reassessed** at least every 6 months May be face to face, virtual, or via phone.	**Required at intake** **Reassessed** at least annually May be face to face, virtual, phone, or email.	**Required at intake** **Reassessed** at least annually May be face to face, virtual, phone, or email.	**Required at intake (however, brief assessment is allowed).** **Reassessed** at least annually May be face to face, virtual, phone, or email.
Service Plan	**Required** The Service Plan is updated when: • Unanticipated changes take place in the client's life, • A change in the plan is identified, • Or at least every 6 months when reassessment occurs.	**Required** The Service Plan is updated when: • Unanticipated changes take place in the client's life, • When a change in the plan is identified, • Or at least every 6 months when reassessment occurs.	**Not Required**	**Not Required**
Referral	• The provider will document all referrals. • The provider will document follow-up activities and outcomes in the record. • The provider will utilize a tracking mechanism to monitor completion of all case management referrals.	• The provider will document all referrals. • The provider will document client reported follow-up and outcomes in the record.	The provider will document all referrals.	The provider will document all referrals, and will refer back into case management if client shows a need or desire for a more intense level ofservice.

CORE ELEMENTS	*Medical Case Management*	*Non-Medical Case Management*	*Care Navigation*	*Referral for Services*
Access to and coordination with medical care	• Coordination and follow up of medical treatment. • Providers shall maintain regular communication with client's primary care provider. • Assist with scheduling appointments, following up on missed appointments and adherence planning.	• Client reports on ability to self-manage care. • Assistance with coordination is provided upon request.	Not Required	Not Required
Adherence	• Development and implementation of adherence plan. • Plan is updated at least every 6 months.	Client reported.	Not Required	Not Required
Transition between tiers	Movement can take place at any time, after assessment shows stability, or at request of client.	Movement can take place at anytime, after assessment shows stability or a need and/or desire for a more/less intense level of service.	Movement can take place at any time, after assessment shows a need and/or desire for a more/less intense level of service.	Movement can take place at any time, after client shows a need and desire for a more intense level of service.
Service Unit	A "service unit" of medical case management is defined as a visit or encounter lasting 15 minutes or less, face to face, virtually, via telephone, email, texting, or other mechanism used to provide the service.	A "service unit" of nonmedical case management is defined as avisit or encounter lasting 15 minutes or less, face to face, virtually, via telephone, email, texting, or other mechanism used to provide the service.	A "service unit" of care navigation is defined as a visit or encounter lasting 15 minutes or less, face to face, virtually, via telephone, email, texting, or other mechanism used to provide the service.	A "service unit" of Referral Services is defined as a visit or encounter lasting 15 minutes or less, face to face, virtually, via telephone, email, texting, or other mechanism used to provide the service.

HIV RESOURCES
DENVER PUBLIC HEALTH & ENVIRONMENT

DENVER HIV RESOURCES PLANNING COUNCIL

Medical Case Management

Medical Case Management is a proactive case management model intended to serve persons living with HIV with multiple complex medical and/or adherence health-related needs. The model is designed to serve individuals who may require assistance with access, utilization, retentionand adherence to primary health care services. Medical Case management clients need or want ongoing support from case management to actively engage in medical care, and continued adherence to treatment. Medical Case Management services focus on improving health care outcomes.

Medical case management services offer a range of client-centered services that link clients with health care, psychosocial, and other services. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management services will be culturally, and linguistically appropriate to the communities served. Medical case management may be delivered face-to-face, via telephone, or utilizing other forms of communication appropriate for the client. A primary goal of Medical case management is to assist the clients in moving toward empowerment, self-determination, and self-sufficiency. This allows the provider to transition clients to more appropriate programs and services as the client's medical and psychosocial status improves, freeing valuable resources for people who are most in need.

A "**service unit**" of Medical Case Management is defined as a visit or encounter lasting 15 minutes or less. This can be either face to face, virtually, via telephone, email, texting, or other mechanism used to provide Medical Case Management services.

Key activities

- Intake and eligibility determination for Ryan White services
- Assessment and reassessment
- Service Plan development
- Implementing and monitoring the Service Plan
- Coordination of services (medical or otherwise)
- Adherence Planning (for HIV and other Medications)
- Referral and follow up
- Transition and case closure
- Records management
- Case load management
- Address other barriers and make referrals as needed, including but not limited to: mental health, substance use, food bank, medical transportation, etc.
- Managing Ryan White emergency financial assistance, housing, oral health, legal assistance, and HOPWA requests

At a minimum, medical case management must include the following:

- Provision of treatment and adherence education to ensure readiness for, and adherence

to, complex HIV treatments.

- Coordination and follow-up of medical treatments
- Client-specific advocacy and/or review of utilization of services
- Motivating and assisting clients to access long-term support for health care costs, including Medicaid, Medicare, COBRA, the Colorado Indigent Care Program (CICP), group or individual health+ insurance, coverage under someone else's health insurance policy, and pre-existing condition insurance plans.

Providers must also maintain proficiency regarding the following care-related services and must collaborate with the providers of such services:

- Colorado's State Drug Assistance Program (formerly known as "ADAP")
- Colorado's HIV Insurance Assistance Program, including Bridging the Gap, Colorado
- The Housing Opportunities for People with AIDS (HOPWA) program, administered by the Colorado department of Local Affairs, Division of Housing

Units of Service

15 minutes or less

Service Components

STANDARD	CRITERIA	DOCUMENTATION
Initial Assessment		
A. Key information concerning the client, family, caregivers and informal supports is collected and documented to determine client enrollment eligibility, need for ongoing case management services, and appropriate level of case management service.	**A.1** Intake must be completed when a client living with HIV is requesting services for the first time. If a client has emergency needs that must be satisfied, an intake can be completed at the earliest convenience of the client. However, the initial intake must be initiated, not necessarily completed within 7-10 days.	The client record should document eligibility in terms of Denver TGA residency, HIV status, and income, as described in the Universal Standards. The client record should also document: • Date of intake • Source of referral • Contact information – home and mailing address, phone, emergency contact, preference on how to contact • Age/ Date of birth • Gender • Racial or ethnic identification • Year and location of diagnosis • Location of current medical care • Documentation of health insurance, (if applicable) • Any other current or chronic medical condition/need for care • All current medications

		• Household/current living situation • Current employment • Documentation of any current financial income/ pay stub • Education level • Social support • Whether basic needs are met (food, shelter, etc.) • History of incarceration/ parole status • Signed release of information, when applicable • Evidence the provider explained, and the client received the following: • Client rights and responsibilities • Client grievance procedure • Information on confidentiality
B. Working collaboratively with the client, the provider conducts a confidential, comprehensive, face-to-face or phone needs assessment to assess the need for medical, dental, psychosocial, educational, financial, nutritional, mental health, substance use, risk reduction, and other services.	**B.1.** The provider conducts a needs assessment with the following intake to case management services. As a client's status changes, it will be necessary for the provider to reassess their needs and acuity level. The provider should use an acuity scale as a measurement tool to determine client needs. The acuity scale indicates: • The level of case management complexity • The frequency of contact • The complexity of the provider's overall caseload	A completed assessment form in the client record covering the following: ▪ Medical, mental health, substance use, psychosocial needs, and basic needs (food, shelter, etc.). A completed acuity level scale in the client's record, including: ▪ Client's current level of need ▪ Evidence that the assessment was completed ▪ Evidence of client is assigned to case management tier based on acuity score. ▪ Evidence acuity level has been updated as needed **Note:** Tools used for assessment and acuity determination available via DHR or CDPHE. Other assessment tools may include the Client Diagnostic Questionnaire (CDQ), Substance Abuse & Mental Illness Symptom Screener (SAMISS) and the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)which is used in the context of SBIRT.
C. Medical case management services should be responsive to the current situation of the client.	**C.1.** Reassessment of the client's needs is conducted as needed, but not less than once every six months.	Documentation of reassessment in the client file.

Service Planning		
D. The client's individualized service plan is a strengths-based case management work plan, which systematically identifies agreed upon client needs based on a client assessment. The service plan worksheet shall be completed and utilized by the provider and the client. Clients should receive medical case management that is centered on their needs, and based on client priorities.	**D.1.** The service plan is a strategy or plan of action designed by both the provider and client as a means to help the client achieve goals. Needs, goals, and tasks are identified and prioritized, including any outcome measures mandated by the agency or funding source. Service plan written in a SMART format includes: ▪ **S**pecific- Goals, Objectives and tasks should specify what the person wants to achieve ▪ **M**easurable- You and the person should be able to measure whether the goals, objectives and tasks are being achieved. ▪ **A**chievable- Are the goals, objectives and tasks achievable and attainable? ▪ **R**ealistic- Can the person realistically achieve the goals, objectives and tasks with the resources /they have? ▪ **T**ime Framed- Is there a specific timeframe set for each goal, objective and task? ▪ **S**trength-based –Were the person's strengths and resources used in developing the goals objectives and tasks?	All service plans are entered and updated in the agency's data system. Service plan written in a SMART format indicates: ▪ Goals ▪ Action steps ▪ Actual outcomes ▪ Changes or updates ▪ Follow up At least one goal in the service plan should address health and wellness related to HIV, such as barriers, adherence, or medical care.
E. The provider and client will work together to decide a timeline and who will take responsibility for each task.	**E.1.** A reasonable timeline is determined for achievement of goals, with tasks assigned to either provider or client.	The service plan indicates the individual responsible for each task: • Provider (ex. Case Manager) • Client • Family or support • Other staff or agency The Service Plan indicates anticipated time frame for each task.
F. Reassessment is completed as needed, but not less than once every six months.	**F.1.** The service plan is updated for those clients actively seeking services, including those clients identified as needing services by	Provider will document all updates to the service plan upon achievement of goals, when other issues or goals are identified, or at least

	other providers, when unanticipated changes take place in the client's life, when a change in the plan is identified, upon achievement of goals, or at least every six months when reassessment occurs.	every six months, when reassessment should occur.
G. Medical case management should be relevant to the client's current situation.	**G.1.** The strategy or plan of action should be consistent with the updated service plan including: • Assistance in arranging services, making appointments, and confirming service delivery dates • Encouragement to client to carry out tasks they agreed to • Support to enable clients to overcome barriers and access services • Negotiation and advocacy as needed • Other case management activities as needed	Progress notes signed and dated by the provider detailing the action taken should be in the client file. This should include ongoing documentation of the following: • Progress made towards service planAction taken to overcome barriers
H. Determination of the need for service plan revision.	**H.1.** Provider will revise service plan as changes in client circumstances warrant.	Provider will document all updates to the service plan.
Referrals and Care Coordination		
I. Provider will provide referrals, advocacy, and interventions based on the service plan.	**I.1.** Providing a referral may include: • Providing referral contact information (in person, by phone, email, or in writing, etc.) • Conducting ongoing follow-up with clients and providers to confirm completion of referrals, service acquisition, maintenance of services, and adherence to medical care • Actively following up on established goals in the service plan to evaluate client progress and determine appropriateness of services • Assisting clients in resolving	The client record includes ongoing documentation of the following: • Specific data about all encounters with the client, including date of encounter, type of encounter, duration of encounter, and services provided • All medical case management contacts with the client's support system, providers, and other participants • Changes in client status or circumstances • Progress made towards service plan • Barriers identified in goal process and actions taken to resolve them Current status and results of linked referrals

	any barriers to completing goals in the service plan	
J. Each client receiving medical case management services will receive referrals to those services critical to achieving optimal health and well-being.	**J.1.** The provider will support the client to initiate referrals that were agreed upon by the client and the provider. Referrals include: ▪ Referral to a named agency ▪ The name of a contact person at the referral agency ▪ An exact address ▪ Specific instructions on how to make the appointment ▪ Identifying referral agency eligibility requirements ▪ What to bring to the appointment.	All of the elements of referral should be documented in the client record.
K. As appropriate, providers shall facilitate referrals by obtaining releases of information to permit provision of information about the client's needs and other important information to the service provider.	**K.1.** Signed release of information forms are obtained as necessary.	Signed release of information should be included in the client's record when necessary.
L. Each client will receive assistance to help problem solve when barriers impede access.	**L.1.** The provider will work with the client to identify barriers to referrals and assist in finding culturally responsive solutions to address barriers.	The provider will document all barriers identified in referral process and the actions taken to resolve them.
M. The provider will ensure clients are accessing needed referrals.	**M.1.** The provider will utilize a tracking mechanism to monitor completion of all referrals.	The provider will document follow-up activities and outcomes in the client record.
N. Providers shall maintain communication with client's primary care provider.	**N.1.** Providers will make contact with a client's primary care clinic at a minimum of twice a year, or as clinically indicated.	Client file must include: • HIV care medical provider name/clinic • Documentation of contact with primary medical clinics and providers • Medical history • All current medications • Date of last clinic visit • Results of last CD4 and viral load

		It is strongly preferred that this clinical data be reported directly from the medical provider and not rely on client self-report.
O. Clients who are not engaged in care should be referred to a primary care physician.	**O.1.** If a patient is not seeing a primary care physician regularly, they should be urged to seek care, and a referral to a primary care physician should be made.	There should be evidence in the client record that a culturally responsive method was used, including but not limited to motivational interviewing, trauma informed care, etc. approach was used in regard to seeking HIV care. Referral should be documented in client file.
P. Case reviewing utilized as a specific mechanism to enhance case coordination.	**P.1.** Interdisciplinary case review should be held for each client at least annually, or more often if clinically indicated.	Evidence of timely case reviewing with key providers is found in the client's records. Case reviews may take place face-to-face, by phone, or electronically. This may involve clients operating as a "go between" with the provider.
Adherence Planning		
Q. Adherence should be assessed and then discussed with the client. Any needed Adherence plan should be developed concurrently and collaboratively with the client.	**Q.1.** The adherence plan should address both medical and non-medical needs and reflect compliance of adherence counseling standards of care.	The written adherence plan in the client record should, strive to include: • Treatment education • Side effect management • Nutritional counseling • The use of reminder tools, when appropriate • Trauma Informed Care, and Motivational interviewing in support of mental health and substance abuse counseling • Relapse prevention and management strategies • Other practical strategies that support adherence
Transition/Case Closure		
R. At the conclusion of medical case management services, the client's goals should have been met and, when appropriate, there should be a seamless transition to less intensive case management services (such as nonmedical	**R.1.** Clients should demonstrate one of the medical case management case closure criteria.	Client records should demonstrate one or more of the following case closure criteria being met: • Successful completion of all the goals in the service plan • Transition to a different level of case management continuum of care when applicable • Voluntary withdrawal from the service • Death of the client • Relocation outside of the service area

case management or care navigation) or case closure.		• Client otherwise lost to the service • (moved out of jurisdiction, unable to locate after multiple attempts, etc.) • Client demonstrates the ability to • independently manage their care in a sustainable manner Severe, inappropriate, threatening, or otherwise destructive behavior on the part of the client that makes continuation of services dangerous to the provider or unlikely to be helpful to the client
S. The Provider will complete a transition/case closure summary.	**S.1.** All attempts to contact the patient and notifications about case closure will be documented in the patient file, along with the reason for transition/case closure.	Transition/case closure summaries will include: • Date and signature of Provider (may consist of date stamp/electronic signature in EHR/EMR) • Date of transition/case closure • Status of the service plan • Status of primary health care and support service utilization Reasons for case closure and criteria for re-entry into services
Confidentiality/Documentation		
T. Case management records will reflect compliance with the case management standards of care. Records should be complete, accurate, confidential, and secure.	**T.1.** All client record progress notes will document the date, the type of encounter, and description of the encounter. Transportation of client records should be handled only by authorized personnel and in a manner to ensure security and confidentiality.	There is one record per client. Each client record entry includes: date of client visit/contact, reason for visit/contact, any activities performed, outcome plan, and follow-up.
Staff Qualifications		
U. Medical case management staff should be appropriately qualified and trained.	**U.1.** Personnel files should document that Medical case management staff are appropriately credentialed or demonstrate sufficient mastery of skill and knowledge to deliver the service. Medical case management staff will have a one-year period starting on their date of hire to document their qualifications.	Personnel records should document qualification of providers by the following means: • As applicable, a copy of a license or certificate as a medical professional (e.g., a physician, nurse, or medical social worker); Official transcripts or certificates showing successful completion of courses of study of the areas listed below; and • Completion of the MCM Certificate Online Training (available through DHR).

		This is in addition to the required trainings outlined in the Universal Service Standards.
V. Medical case management staff should receive appropriate supervision.	**V.1.** All medical case management staff must be supervised by a supervisor who meets same requirement as standard U., and who regularly reviews the client files, acuity and service plans. Supervisory files should document supervisory activities, including direct observation of services, follow up actions, and effort to improve service quality.	Personnel records should document qualifications of direct supervisor of providers. • Supervisory files should contain the following: A copy of a license or certificate as a medical professional (e.g., a physician, nurse, or medical social worker); Official transcripts or certificates showing successful completion of courses of study of the areas listed below; and • Completion of the MCM Certificate Online Training (available through DHR). • Evidence of training or quality improvement activities • Evidence staff received supervision • Evidence of client file reviews • Evidence of follow up action taken
X. Meet the client where they are at.	**X.1.** Providers ensure that client services are designed and provided in a way that supports the client but does not require participation in any element unless the client is willing.	Client file demonstrates that if a client does not want to participate in a component of case management services, or does not prioritize an element, it is noted in the file and CM will reevaluate at the next assessment date.

Non-Medical Case Management

Non-Medical case management is a proactive case management model intended to serve persons living with HIV with multiple complex psychosocial needs and their families/close support systems. The model is designed to serve individuals who may require or want ongoing case management support to stabilize their psychosocial needs. Non-medical case management is also an appropriate service for clients who have completed medical case management but still require a maintenance level of periodic support from the provider (case manager or case management team). Non-medical case management clients manage their care well enough to avoid chronic disruption to their medical care but require psychosocial support to maintain a stable lifestyle.

Non-medical case management may also be provided to clients with multiple complex needs who may best be served by a medical case management program, but who are not ready or willing at this time to engage in the level of participation required by the medical case management model. In this case, non-medical case management serves as a means of assisting an individual at his/her/their level of readiness, while encouraging the client to consider more comprehensive services. Non-medical case management services provides guidance and assistance in improving access to and retention in needed core and support services.

Non-medical case management model includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.

A "**service unit**" of Non-Medical Case Management is defined as a visit or encounter lasting 15 minutes or less. This can be either face to face, virtually, via telephone, email, texting, or other mechanism used to provide Non-Medical Case Management services.

Key activities include:

- Intake and eligibility determination for Ryan White services
- Assessment and re-assessment of service needs
- Development of a brief, individualized service plan
- Client monitoring to assess the efficacy of the plan
- Periodic re-evaluation and adaptation of the plan as necessary
- Address other barriers and make referrals as needed, including but not limited to: mental health, substance use, food bank, medical transportation, etc.
- Managing Ryan White emergency financial assistance, housing, oral health, legal assistance, and HOPWA requests

At a minimum, non-medical medical case management must include the following:

- Client-specific advocacy and/or review of utilization of services
- Motivating and assisting clients to access long-term support for health care costs, including Medicaid, Medicare, COBRA, the Colorado Indigent Care Program (CICP), group or individual health insurance, coverage under someone else's health insurance policy, and Cover Colorado.

Providers must also maintain proficiency regarding the following care-related services and must collaborate with the providers of such services:

- Colorado's State Drug Assistance Program (formerly known as "ADAP")
- Colorado's HIV Insurance Assistance Program, including Bridging the Gap, Colorado.
- The Housing Opportunities for People with AIDS (HOPWA) program, administered by the Colorado Department of Local Affairs, Division of Housing

Units of Service

15 minutes or less

Service Components

STANDARD	CRITERIA	DATA SOURCE
Initial Assessment		
A. Key information concerning the client, family, caregivers and informal supportsis collected and documented to determine client enrollment eligibility, need for ongoing case management services, and appropriate level of case management service.	**A.1** Intake must be completed when a client living with HIV is requesting services for the first time. If a client has emergency needs that must be satisfied, an intake can be completed at the earliest convenience of the client, but nolater than two weeks after initial contact.	The client record should document eligibility in terms of Colorado residency, HIV status, and income, as described in the Universal Standards. The client record should also document: • Date of intake • Source of referral • Contact information – home and mailing address, phone, emergencycontact; preference on how to contact • Age/ Date of birth • Gender • Racial or ethnic identification • Year and location of diagnosis • Source of any current medical care • Documentation of health insurance,(if applicable) • Household/ current living situation • Current employment • Documentation of any current financial income/ pay stub • Education level • Social support • Whether basic needs are met (food, shelter etc.) • History of incarceration/ parole status • Signed release of information • Evidence the provider explained, and the client receivedthe following: ○ Client rights andresponsibilities ○ Client grievance procedure ○ Information on confidentiality

B. Working collaboratively with the client, the provider conducts a confidential assessment of client's immediate needs.	**B.1** The provider conducts a Needs Assessment with the client following intake to case management services. As a client's status changes, it will be necessary for the provider to reassess their needs and acuity level. The provider should use an acuity scale as a measurement tool to determine client needs. The acuity scale indicates: • The level of case management complexity • The frequency of contact The complexity of the caseload	A completed assessment form in the client's record covering the following • Medical, mental health, substance use, psychosocial needs, HIV risk behaviors, and basic needs (food, shelter, etc.). A completed acuity level scale in theclient's record, including: • Client's current level of need • Evidence that the assessment was completed • Evidence of client is assigned to case management tier based on acuity score. • Evidence acuity level has been updated as needed Note: Tools used for assessment and acuity determination available via DHR or CDPHE. Other assessment tools may include the Client Diagnostic Questionnaire (CDQ), Substance Abuse & Mental Illness Symptom Screener (SAMISS) and the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)which is used in the context of SBIRT.
C. Non-medical case management should be responsive to the current situation of the client.	**C.1** Reassessment of the client's needs is conducted as needed, but not less than annually.	Documentation of reassessment in theclient files
Service Planning		

D. The client's individualized service plan is a case management work plan which systematically identifies agreed upon client needs based on a comprehensive client assessment. The service plan worksheet shall be completed and utilized by the provider and the client.	**D.1** The service plan is a strategy or plan of action designed by both provider and client as a means to help the client achieve goals. Problems, goals, and tasks are identified and prioritized, including any outcome measures mandated by the agency or funding source. Service plan written in a SMART format includes: • Specific- Goals, Objectives and tasks should specify what the person wants to achieve • Measurable- You and the person should be able to measure whether the goals, objectives and tasks are being achieved. • Achievable- Are the goals, objectives and tasks achievable and attainable? • Realistic- Can the person realistically achieve the goals, objectives and tasks with the resources /they have? • Time Framed- Is there a specific timeframe set for each goal, objective and task? Strength-based –Were the person's strengths and resources used in developing the goals objectives and tasks?	All service plans are entered and updated in the data system provided byDHR, or an approved equivalent. Service plan written in a SMART format indicates: • Goals • Action steps • Actual outcomes • Changes or updates • Follow up
E. The provider and the client will work together to create a timeline and decide who will take responsibility for each task.	**E.1.** A reasonable timeline is determined for achievement of goals, with tasks assigned to either the provider or client.	The service plan indicates the individual responsible for each task: • Provider (ex. Case manager) • Client • Family or support • Other staff or agency The service plan indicates anticipated time frame for each task

F. Reassessment of client needs is completed as needed, but not less than every six months.	**F.1.** The service plan is updated for those clients actively seeking services, including those clients identified as needing services by other providers, when unanticipated changes take place in the client's life, when a change in the plan is identified, upon achievement of goals or at least annually when reassessment occurs.	The Provider will document all updates to the service plan upon achievement of goals, and when other issues or goals are identified, or at leastannually when reassessment should occur.
G. Clients should receive non-medical case management that is suited to their situation.	**G.1.** The service plan should be consistent with needs identified in the comprehensive client assessment.	The service plan should be signed and dated by the provider and client in the client's file.
H. Non-medical case management should be relevant to the client's current situation.	**H.1** The strategy or plan of action should be consistent with the updated service plan including: • Refer client needed services • Encouragement to client to carry out tasks they agreed to • Support to enable clients to overcome barriers and access services • Negotiation and advocacy as needed • Other case management activities as needed	Progress notes signed and dated by the provider detailing the action taken should be kept in the client's file. Ongoing documentation of the following should also be kept in the client's file: • Progress made towards service plan • Action taken to overcome barriers
Referrals and Care Coordination		
I. The provider will provide referrals, advocacy, and interventions based on the service plan.	**I.1** Monitoring involves carrying out of tasks listed in the plan, including the following activities: • Provider contact in person, by phone, or in writing • Assistance to client in applications for services • Assistance in arranging services • Encouragement to client to carry out tasks they agreed to • Support to enable clients to overcome barriers and access services • Negotiation and advocacy as needed • Other case management activities as needed	The client record includes ongoing documentation, signed and dated by the provider, of the following: • All client contacts including: of encounter ○ Date of encounter ○ Type of encounter ○ Duration of encounter ○ Services provided • All case management contacts with the client's support system, providers, and other participants • Changes in client status Progress made towards service plan

J. Each client receiving non-medical case management services will receive referrals to those services critical to achieving optimal health and well-being.	**J.1** The provider will support the client to initiate referrals that were agreed upon by the client and the provider. Referrals include: • Referral to a named agency • The name of a contact person at the referral agency • An exact address • Specific instructions on how to make the appointment • Identifying referral agency eligibility requirements What to bring to the appointment	All of the elements of referralshould be documented in the client record.
K. As appropriate, providers shall facilitate referrals by obtaining releases of information to permit provision of information about the client's needs and other important information to the service provider.	**K.1.** Signed release of information forms are obtained as necessary.	Signed release of information in client's record.
L. Each client will receive assistance to help problem solve when barriers impede access.	**L.1.** The provider will work with the client to identify barriers to referrals and assist in finding solutions to address barriers.	The provider will document all barriers identified in referral process and actions taken to resolve them.
M. The provider will ensure clients are accessing needed referrals.	**M.1.** Provider will utilize a tracking mechanism to monitor completion of all referrals.	The provider will document follow-up activities and outcomes in the client record.
Transition/Case Closure		
N. At the conclusion non-medical case management services, the client's goals should have been met and, when appropriate, there should be a seamless transition to less or more intensive case management services. If the client's needs were not met, or the transition did not occur, the reasons	**N.1** Clients should demonstrate one of thenon-medical case management case closure criteria.	Client records should demonstrate one or more of the following case closure criteria being met: • Successful completion of all the goals in the service plan • Transition to a different level of case management continuum of care when applicable • Voluntary withdrawal from the service • Death of the client • Relocation outside of the service area • Client otherwise lost to the service (moved out of jurisdiction, unable

should be appropriate and well-documented.		to locate after multiple attempts, etc.) • Client demonstrates the ability to independently manage their care in a sustainable manner Severe, inappropriate, threatening, or otherwise destructive behavior on the part of the client that makes continuation of services dangerous to the provider or unlikely to be helpful to the client
O. Provider will complete a transition/case closure summary.	**O.1** All attempts to contact the patient and notifications about case closure will bedocumented in the patient file, along with the reason for transition/case closure.	Transition/case closure summaries will include: • Date and signature of the provider • Date of transition/case closure • Status of the service plan • Status of primary health care and support service utilization • Reasons for transition/case closure and criteria for re-entry into services
Confidentiality/Documentation		
P. Case management records will reflect compliance with the non-medical case management standards of care. Records should be complete, accurate, confidential, and secure.	**P.1** A client record progress notes will document the date, the type of encounter, and description of the encounter. Transportation of client records should be handled only by authorized personnel and in a manner to ensure security and confidentiality.	There is one record per client. Each client record entry includes date of client visit/contact, reason for visit/contact, any activities performed, outcome plan, and follow-up.
Staff Qualifications		
U. Providers should be appropriately qualified and trained.	**U.1.** Personnel files should document that providers are appropriately credentialed or demonstrate sufficient mastery of skill and knowledge to deliver the service. Providers will have a one-year period starting on their date of hire to document their qualifications.	Personnel records should document qualification of providers by the following means: • As applicable, a copy of a license or certificate as a medical professional (e.g., a physician, nurse, or medical social worker); Official transcripts or certificates showing successful completion of courses of study of the areas listed below; and

		• Completion of the MCM Certificate Online Training (available through DHR). This is in addition to the required trainings outlined in the Universal Service Standards.
X. Meet the client where they are at.	**X.1.** Providers ensure that client services are designed and provided in a way that supports the client but does not require participation in any element unless the client is willing.	Client file demonstrates that if a client does not want to participate in a component of case management services, or does not prioritize an element, it is noted in the file and CM will reevaluate at the next assessment date.

Care Navigation

Care Navigation is intended to assist people living with HIV in accessing services and decision-making for their health-related and/or psychosocial needs. This model is designed to assist individuals whose needs are minimal and infrequent. It may also be used to provide services to those who do not want or are not ready to engage in more intensive case management services.

Care Navigation strives to provide a varying level of support to a client's need. When receiving Care Navigation services, the client may receive assistance in obtaining medical, social, community, legal, financial, and other needed services. However, Care Navigation does not involve coordination and follow-up of medical treatments, as medical case management does. Care Navigation also does not include the development and monitoring of a treatment plan.

Clients who are newly diagnosed, or new to the Denver system should have an opportunity to have a period of more intensive service (either medical or non-medical case management) to ensure needs have been met prior to being transferred to Care Navigation. Movement from Care Navigation into a more intensive tier can happen at any time client identifies a need, or if reassessment indicates that more support is needed.

A "**service unit**" of care navigation is defined as a visit or encounter lasting 15 minutes or less. This can be either face to face, virtually, via telephone, email, texting, or other mechanism used to provide Care Navigation services.

Key activities

- Initial assessment of service needs
- Periodic re-assessment of service needs
- Address other barriers and make referrals as needed, including but not limited to: mental health, substance use, food bank, medical transportation, etc.

- Managing Ryan White emergency financial assistance, housing, oral health, legal assistance, and HOPWA requests

Providers must also maintain proficiency regarding the following care-related services andmust collaborate with the providers of such services:

- Colorado's State Drug Assistance Program (formerly known as "ADAP")
- Colorado's HIV Insurance Assistance Program, including Bridging the Gap, Colorado
- The Housing Opportunities for People with AIDS (HOPWA) program, administered by the Colorado Department of Local Affairs, Division of Housing

Service Units

1 unit = 15 minutes or less

Service Components

STANDARD	MEASURE	DATA SOURCE
Initial Assessment		
A. Working collaboratively with the client, the provider conducts a confidential assessment of client's immediate needs.	**A.1** The provider conducts a needs assessment at least annually or at the client's request. As a client's status changes, it will be necessary for the provider to reassess their needs and acuity level. The provider should use an acuity scale as a measurement tool to determine client needs. The acuity scale indicates: • The level of case management complexity • The frequency of contact • The complexity of the provider's overall caseload The provider must contact the client at least once during the year prior to reassessment to offer assistance. This contact may be by phone, mail, or in person.	A completed assessment form in the client's record covering the following: • Medical, mental health, substance use, psychosocial needs, and basic needs (food, shelter, etc.). A completed acuity level scale in the client's record, including: • Client's current level of need • Evidence that the assessment was completed • Evidence of client is assigned to case management tier based on acuity score. • Evidence acuity level has been updated as needed Note: Tools used for assessment and acuity determination available via DHR or CDPHE. Other assessment tools may include the Client Diagnostic Questionnaire (CDQ), Substance Abuse & Mental Illness Symptom Screener (SAMISS) and the Alcohol, Smoking and Substance Involvement Screening Test

		(ASSIST)which is used in the context of SBIRT.
B. Clients should be able to base their health care decisions on accurate, understandable information about their healthcare and support service options.	**B.1** Clients should be assessed and counseled regarding resources and programs that might be available to them based on their identified needs. Clients should be assessed for the Colorado's State Drug Assistance Program (formerly known as "ADAP"), including both Medication Assistance and Insurance Assistance.	The client record should include information related to the client needs assessment and detail the available resources that were provided to the client. include
Referrals and Care Coordination		
C. The provider will develop referral resources to make available the full range of additional services to meet the needs of their clients.	**C.1** Provider will develop and maintain comprehensive referral lists for a full range of services.	Referral lists available upon request by DHR.
D. Providers will demonstrate active collaboration other agencies to provide referrals to the full spectrum of HIV-related and other needed services.	**D.1.** Provider will collaborate with other agencies and providers to provide effective, appropriate referrals.	Memoranda of Understanding with services providers on file.
E. Each client receiving Care Navigation services will receive referrals to those services critical to achieving optimal health and well-being.	**E.1.** The provider will support the client to initiate referrals that were agreed upon by the client and the provider.	The provider will document when referrals are made as well as attempts to verify follow up of referrals.
Transition/Case Closure		
F. At the conclusion of Care Navigation services, the client's goals should have been met and, when appropriate, there should be a seamless transition to more	**F.1** Clients should demonstrate one of the brief contact management case closure criteria.	Client records should demonstrate one or more of the following case closure criteria being met: • Voluntary withdrawal from the service • Death of the client • Relocation outside of the service area

intensive case management services.		• Client otherwise lost to the service (moved out of jurisdiction, unable to locate after multiple attempts, etc.) • Client no longer demonstrates the ability to independently manage his/her/their care. Transition to a different level of case management continuum of care when applicable. This typically occurs when client needs are more appropriately addressed in a more intense level of service.
G. provider will complete a transition/case closure summary.	**G.1.** All attempts to contact the patient and notifications about case closure will be documented in the patient file, along with the reason for transition/case closure.	Transition/case closure summaries will include: • Date and sign-off of provider • Date of transition/case closure • Reasons for transition/case closure Criteria for re-entry into services
Confidentiality/Documentation		
H. Care Navigation records should be complete, accurate, confidential and secure.	**H.1**. Client record progress notes will document the date, the type of encounter and description of the encounter. Storage and transportation of client records should be handled only by authorized personnel and in a manner to ensure security and confidentiality.	There is one record per client. Client record entry includes: • Date of client visit/contact • Reason for visit/contact • Any activities performed • Outcome plan
Staff Qualifications		
I. Providers staff should be appropriately qualified and trained.	**I.1.** Personnel files should document that Providers staff are appropriately credentialed or demonstrate sufficient mastery of skill and knowledge to deliver the service. Providers staff will have a one-year period starting on their date of hire to document their qualifications.	Personnel records should document qualification of the provider by the following means: • As applicable, a copy of a license or certificate as a medical professional (e.g., a physician, nurse, or medical social worker); Official transcripts or certificates showing successful completion of courses of study of the areas listed below; and • Completion of the MCM Certificate Online Training (available through DHR).

		This is in addition to the required trainings outlined in the Universal Service Standards.
X. Meet the client where they are at.	**X.1.** Providers ensure that client services are designed and provided in a way that supports the client but does not require participation in any element unless the client is willing.	Client file demonstrates that if a client does not want to participate in a component of case management services, or does not prioritize an element, it is noted in the file and CM will reevaluate at the next assessment date.

Referral for Health Care and Support Services

Referral Services is intended to assist people living with HIV who were formerly engaged in more intensive tiers of case management and have progressed to self-management, or are only in need of Referral Services at this time. Referral Services assist clients to connect with needed core medical or support services and may be provided in person or through telephone, written, or other type of communication. Referral Services is intended to assess the sufficiency of self-management and to provide additional services as indicated by the client. Referral Services clients may have low acuity or may have high acuity but do not want to engage in more intensive case management services at this time.

A "**service unit**" of Referral Services is defined as a visit or encounter lasting 15 minutes or less. This can be either face to face, virtually, via telephone, email, texting, or other mechanism used to provide Referral Services.

In order to qualify as a "service unit" under "Referral Services", the service must have been provided as a stand-alone service, outside the context of any other service such as ongoing case management or linkage to care. This may mean that the service was provided to a client who is not engaged in case management services, or it may mean that the client is seeking a onetime referral service from someone who is not their provider (case manager).

Key activities

- Providing enrollment and eligibility assistance for Ryan White services
- Address identified barriers and make referrals as needed, including but not limited to: mental health, substance use, food bank, medical transportation, etc.
- Managing Ryan White emergency financial assistance, housing, oral health, legal assistance, and HOPWA requests

Service Units

1 unit = 15 minutes or less

Service Components

STANDARD	MEASURE	DATA SOURCE
Initial Assessment		
A. Working collaboratively with the client, the provider conducts a confidential assessment of client's immediate needs. If client opts out then not required to complete service.	**A.1.** The provider conducts a brief needs assessment annually, beginning at the time of service, or at the client's request. Part of this assessment should be notifying the client about other case management services. As a client's situation changes, it may be necessary for the provider to reassess their needs and acuity level. The provider should use an acuity scale as a measurement tool to determine client needs (abbreviated tool may be used). The acuity scale indicates: The level of case management complexity • The frequency of contact • The complexity of the provider's overall caseload The provider must contact the client at least once during the year prior to reassessment to offer assistance. This contact may be by phone, mail, email, or in person.	A completed assessment form in the client's record covering the following: • Medical, mental health, substance use, psychosocial needs, and basic needs (food, shelter, etc.). A completed acuity level scale in the client's record, including: ○ Client's current level of need ○ Evidence that the assessment was completed ○ Evidence of client is assigned to case management tier based on acuity score. ○ Evidence acuity level has been updated as needed If client opts out of assessment and/or acuity this is noted in the clients file. Note: Tools used for assessment and acuity determination available via DHR or CDPHE. Other assessment tools may include the Client Diagnostic Questionnaire (CDQ), Substance Abuse & Mental Illness Symptom Screener (SAMISS) and the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)which is used in the context of SBIRT.
B. Providers should gather sufficient information from or about the client in order	**B.1.** Information collected should include a minimum of: • Name • DOB	Referrals are documented in the client file.

to inform the referral process.	• Phone Number • Other Contact Information • Type of Referral Requested • Reasons for Request	
Referrals and Care Coordination		
C. A referral service or session(s) covers the information necessary for the client to make an informed decision about the referrals offered and provides the necessary information to the client.	**C.1.** The referral service will cover: • When possible, multiple options for referrals to meet the client's needs • Referrals to appropriate consumer assistance offices (HIV service providers, non-profits, governmental agencies, etc.) • Clients will receive name, contact information, and any other information to follow-up on the referral • Hands-on help completing any necessary applications, including paper and web-based applications	Records show that referral services have the required elements.
D. Provider has a referral policy that explains how referrals to other providers are made and tracked.	**D.1.** Provider will detail referral procedures and tracking processes.	Provider has a referral policy on file.
E. Provider will track all referrals made and will document follow-up plan with client and follow-up on referral if agreed upon.	**E.1.** Provider will determine best follow-up plan with the client. If client does not want or need referral follow-up, provider may close referral request. If client would like provider to follow-up, provider will document follow-up plan and contact the client and agency referring to. Clients who would like extensive follow-up may be screened for more intensive case management services. All referrals will be tracked by provider, and follow-up/completion is documented when applicable.	Client file shows follow-up plan, and documents follow-up efforts.
F. Providers will maintain appropriate referral relationships with entities that provide core medical and support services, and are HIV aware, and Trauma Informed. This includes the development of a referral	**F.1**. Provider will develop and maintain comprehensive referral lists for a full range of services. Including but not limited to: • Medical providers; • Oral Health providers;	Referral lists and resources available upon request.

resource document to make available the full range of additional services to meet the needs of their clients.	• Substance Use and Mental Health support programs; • Case Management providers; • Housing Services; • Services supporting those experiencing Homelessness; • Legal Services; • Sexual Health Clinics; • Homeless shelters; • HIV counseling and testing sites; • Financial Assistance Services; • Food and Nutrition Support Services; • Employment/Educational/Income support services; • Vision; • Immigration Services;	
Confidentiality/Documentation		
G. Provider maintains progress notes of all communication between providers and clients. (This can also be used as the tracking and follow-up mechanism as required in **E.**)	**G.1.** Progress notes are kept in client file and detail client's situation, request for referral, type of referral given, and other details related to the referral.	Documentation in client chart.
H. If client needs cannot be met in a single session, providers will actively schedule and follow up on additional sessions.	**H.1**. Clients should receive as many sessions as necessary to complete the referral process. If ongoing support is required, or if many referrals are needed, client should be considered for more intensive case management services.	Client files show scheduling and follow-up on multiple sessions as needed.
J. Provider has policies and procedures in place regarding client consent for requesting or releasing information.	**J.1.** Provider will provide evidence of policies and procedures for client consent for requesting or releasing information.	Client file has release of information on file when necessary (electronic signatures allowable).
Staff Qualifications		
K. Referral Services staff should be appropriately qualified and trained.	**K.1.** Personnel files should document that Referral Services staff are appropriately credentialed or demonstrate sufficient mastery of skill and knowledge to deliver the service.	Personnel records should document qualification of Referral Services staff by the following means: • As applicable, a copy of a

	Referral Services staff will have a one-year period starting on their date of hire to document their qualifications.	license or certificate as a medical professional (e.g., a physician, nurse, or medical social worker); Official transcripts or certificates showing successful completion of courses of study of the areas listed below; and • Completion of the MCM Certificate Online Training (available through DHR). This is in addition to the required trainings outlined in the Universal Service Standards.
X. Meet the client where they are at.	**X.1.** Providers ensure that client services are designed and provided in a way that supports the client but does not require participation in any element unless the client is willing.	Client file demonstrates that if a client does not want to participate in a component of case management services, or does not prioritize an element, it is noted in the file and CM will reevaluate at the next assessment date.

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	**Program's policies and procedures** will contain

	between testing and linkage services, including clear roles, responsibilities, and processes.	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	**Client's file** will contain the Linkage Referral and documentation confirming the client

	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.	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 days of entering EIS not to exceed 90 days.	**Client's file** documents the date of linkage 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 - 500 percent of Federal Poverty Level (FPL)** are eligible for emergency financial assistance not to exceed $1,000 for the current fiscal year. EFA funds may not be used for clothing, or direct cash payments	**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:** Payment for cable is not allowable. - **Water** - **Trash** - **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, medical copayments, 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.	**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 500% FPL, or below.

	Optical: Payments may be made for copayments, prescription eye wear, but not the exam. 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.	
	A.2. In some circumstances clients with extensive medical needs may appeal to DHR for a medical waiver of the limitation on amount if the cap would cause immediate devastating medical harm. To be approved for a medical waiver an individual must: • Submit a waiver request to DHR demonstrating that the limitation on amount guidelines would cause immediate devastating medical harm. • Submit verification from a licensed physician who is providing current medical care for the client, explaining why the limitation on amount guidelines would cause immediate devastating medical harm.	**Client's file** contains complete and signed medical waiver, if applicable.
B. Programs will have procedures for clients to gain EFA assistance,	**B.1.** The client and program will meet in a way that allows client participation (i.e. in person,	**Client's file** contains documentation of client

deny EFA requests, and handle inappropriate use of funds. Eligibility criteria will be applied equally to all clients regardless of program.	virtually, by email, or by phone) to process the housing request.	participation in the process**.**
	B. 2. 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; • Permanent water filtration systems for water entering the house; and • Other non-essential products.	**Provider's policies and procedures** will document un-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	**Program's policies and procedures** document allowable and unallowable costs under RWHAP.

	• If water filtration/ purification systems are provided, community has water purity issues.	
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 Nutrition and Dietetics and HIV/AIDS Evidence-Based Nutrition Practice Guidelines.	**B.1.** Home delivered meals services will follow accepted standards of practice of the Academy of Nutrition and Dietetics, and HIV/AIDS Evidence-Based Nutrition Practice Guidelines.	**Program's Policies and** Procedures contain documentation that program is following 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 0-500 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 rental	**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.

deposits or mortgage payments. Clients who receive a housing subsidy are eligible for housing assistance not to exceed $600 for the current fiscal year.		A family member may be the vendor if they are the property owner. If property owner is an individual, not a company, owner must be verified using the County assessor's website(s). For clients who receive a housing subsidy, documentation of the housing subsidy should be included when requesting housing assistance.
	A.2. In some circumstances clients with extensive medical needs may appeal to DHR for a medical waiver of the limitation on amount if the cap would cause immediate devastating medical harm. To be approved for a medical waiver an individual must: • Submit a waiver request to DHR demonstrating that the limitation on amount guidelines would cause immediate devastating medical harm. • Submit verification from a licensed physician who is providing current medical care for the client, explaining why the limitation on amount guidelines would cause immediate devastating medical harm.	**Client's file** contains complete and signed medical waiver, if applicable.
B. Programs will have procedures for clients to gain	**B.1.** The client and	**Client's file** contains documentation of

housing assistance, deny housing requests, and handle inappropriate use of funds. Eligibility criteria will be applied equally to all clients regardless of program.	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 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 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	**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

the means to access them on their own or need vehicle mileage reimbursement assistance.		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 rideshare trip that is signed by service provider.
		Client's file documents the distribution of the transportation service.

B. The program will provide mileage reimbursement (through a	**B. 1.** The program has a system for providing mileage reimbursement (through a non-cash system) that	**Program's Policies and Procedures** document

non-cash system) that enables clients to travel to needed medical and other support services.	does not exceed the federal per-mile reimbursement rate for the current calendar year.	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; • Licensed Behavioral Health Specialist;	**Personnel File** has proof of certification/ Licensure for the position.
	A.2. Mental health services can be provided by unlicensed registered clinicians or graduate level student interns with appropriate supervision	**Personnel File** clearly designates a supervisor.

	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.	
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 and documented in a timely manner.	**C.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** will contain 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	**Client's File** contains copies of progress notes.

	• 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.	

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	**Client's File** contains copy of treatment plan.

	goal, stating how the client will reach the goals; and • Be updated every six months.	
	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; • 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;	**Client's File** contains copy of closure summary, if patient's case has been closed.

	• 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	**Program's policies and procedures** demonstrate how students are

	guidelines and work under the license of a program's dentist.	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); • 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	**Client's File** will have a signed and dated oral evaluation on file in patient chart.

	• 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 of the dental provider's control (e.g. client missing appointments).	**Client's File** contains progress notes related to treatment plan.
	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	**Client's File** demonstrates the provider is acting ethically and in the best interest of the client.

	Professional Conduct, and respective agencies code of ethics.	
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 - 500 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 surgical and limited endodontic services.	**Program's Policies and Procedures** documents dental services paid for by Ryan White Part A funds.
	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.
F. Upon approval of a dental assistance request, the single payer will hold the requested dollar amount for 90 days.	**F.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.
	F.2. The single payer will inform the requestor of the approval and availability of the requested dollar amount for 90 days, with the date of expiration explicitly stated.	**Single payer records** contain a process for communicating with the requestor.
	F.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.

G. 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.	**G. 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 visitation of any duration

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.	

EXHIBIT G-1

CLINICAL QUALITY MANAGEMENT PLAN TEMPLATE

RWHAP Part A Clinical Quality Management (CQM) Plan Template		
Provider Name: Click or tap here to enter text.	Program Quality Lead: Click or tap here to enter text.	Last Updated: Click or tap to enter a date.
Part A Funded Service Categories:	Core Medical ☐ Early Intervention Services ☐ Medical Case Management ☐ Mental Health ☐ Oral Health ☐ Outpatient Ambulatory Health Services ☐ Substance Abuse Outpatient ☐ Other: Click or tap here to enter text.	Support Services ☐ Emergency Financial Assistance ☐ Housing Services ☐ Food Bank/Home Delivered Meals ☐ Psychosocial Support Services ☐ Transportation ☐ Other Professional Services ☐ Linguistic Services ☐ Other: Click or tap here to enter text.

Clinical Quality Management Priorities for the Denver TGA
Sub-recipient Clinical Quality Plans must address the following priorities addressed in the CQM Plan for the Denver TGA
1. **Access, Engagement, and Retention in Healthcare:** Plans must address how Ryan White Part A Funded services support a client's active involvement with their healthcare. 2. Health Outcomes: Plans must address how Ryan White Part A funded services support a client's viral suppression and other health and wellness goals including medication adherence. 3. End Disparities Efforts: Plans must describe how Ryan White Part A funded services impact the following communities' access to and engagement with services and treatment. The communities are Transgender, MSM of Color, African American and Latina Women, and Youth ages 13-24. 4. Client Experience and Satisfaction: Plans must describe efforts and to understand clients' experience with Ryan White Part A funded services and their satisfaction with those services.

Quality Statement
Describe the ultimate goal of the clinical quality management program
Click or tap here to enter text.

Quality Infrastructure
Describe how leadership guides, endorses, and champions the clinical quality management program
Click or tap here to enter text.
Describe who serves on the quality management committee, who chairs and facilities the meetings, how often the quality management committee meets, and the purpose of the quality management committee
Click or tap here to enter text.
Describe the staff positions responsible for developing and implementing the clinical quality management program and related activities including the role of contractors funded to assist with the clinical quality management program
Click or tap here to enter text.
Describe who writes, reviews, updates, and approves the quality management plan
Click or tap here to enter text.

Describe how people in the community are involved in the development and implementation of the clinical quality management program
Click or tap here to enter text.
Describe how the effectiveness of the clinical quality management program is evaluated
Click or tap here to enter text.

Quality Improvement
Address patient care, health outcomes, ending disparities, and patient satisfaction in quality improvement activities.
Click or tap here to enter text.
Describe the quality improvement approach or methodology used (e.g. Model for improvement/PDSA, Lean, etc.).
Click or tap here to enter text.
Describe how quality improvement projects are documented.
Click or tap here to enter text.

Work Plan (Description)
Provide a thorough overview of implementation, including timelines, milestones, and accountability for all clinical quality management program activities outlined in the quality management plan.
Click or tap here to enter text.
Describe how the work plan will be shared/communicated with all stakeholders, including staff, consumers, board members, parent organizations, other grant recipients, funders, etc.
Click or tap here to enter text.

Work Plan (Matrix)			
Activities	Timeline	Responsible Staff Person	Outcomes
	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

EXHIBIT H-1

CLINICAL QUALITY MANAGEMENT PLAN SUMMARY TEMPLATE

RWHAP Part A Clinical Quality Management (CQM) Plan Summary Template		
Provider Name: Click or tap here to enter text.	Program Quality Lead: Click or tap here to enter text.	Last Updated: Click or tap to enter a date.
Part A Funded Service Categories:	Core Medical ☐ Early Intervention Services ☐ Medical Case Management ☐ Mental Health ☐ Oral Health ☐ Outpatient Ambulatory Health Services ☐ Substance Abuse Outpatient ☐ Other: Click or tap here to enter text.	Support Services ☐ Emergency Financial Assistance ☐ Housing Services ☐ Food Bank/Home Delivered Meals ☐ Psychosocial Support Services ☐ Transportation ☐ Other Professional Services ☐ Linguistic Services ☐ Other: Click or tap here to enter text.

Current State
Describe the current state of your clinical quality management program and improvement projects.
Click or tap here to enter text.

Challenges
Describe the current challenges of your clinical quality management program and improvement projects.
Click or tap here to enter text.

Successes
Describe the current successes of your clinical quality management program and improvement projects.
Click or tap here to enter text.

Clinical Quality Management Priorities for the Denver TGA
Sub-recipient Clinical Quality Plans must address the following priorities addressed in the CQM Plan for the Denver TGA.
1. **Access, Engagement, and Retention in Healthcare:** Plans must address how Ryan White PartA Funded services support a client's active involvement with their healthcare. 2. **Health Outcomes:** Plans must address how Ryan White Part A funded services support a client's viral suppression and other health and wellness goals including medication adherence. 3. **End Disparities Efforts:** Plans must describe how Ryan White Part A funded services impact the following communities' access to and engagement with services and treatment. The communities are Transgender, MSM of Color, African American and Latina Women, and Youth ages 13-24. 4. **Client Experience and Satisfaction:** Plans must describe efforts and to understand clients' experience with Ryan White Part A funded services and their satisfaction with those services.

Denver TGA CQM Priorities
Describe how your Clinical Quality Plan addresses and impacts the Denver TGA priorities (please choose at least 2 priorities).
1. **Access, Engagement, and Retention in Healthcare:** Click here to enter text. 2. **Health Outcomes:** Click here to enter text. 3. **End Disparities Efforts:** Click here to enter text. 4. **Client Experience and Satisfaction:** Click here to enter text.

EXHIBIT I-1

RYAN WHITE PART A SELF ATTESTATION / NO CHANGE FORM

HIV RESOURCES
DENVER PUBLIC HEALTH & ENVIRONMENT

Denver TGA Ryan White Part A
Self-Attestation/No Change Form

Name: _____ **Birth Date:** _____

For Administrative Use Only:
eURN: _____ Start Date: _____ End Date: _____

New Ryan White Eligibility:
Case Manager/ Eligibility Specialist Name: _____

RESIDENCY

Since your Annual Certification six months ago, have you moved/changed residence?

☐ No, my address has not changed.
☐ Yes, my address has changed. *(Please provide new Denver TGA residency documentation)*

HOUSEHOLD SIZE

Since your Annual Certification six months ago, has your household size changed? Household size helps to determine overall income, which affects Ryan White eligibility.

☐ No, there is no change in my household size.
☐ Yes, my household size has changed. *(Please provide new household size)*

INCOME

Since your Annual Certification six months ago, has your income changed?

☐ No, my income has remained the same.
☐ Yes, my income has changed. *(Please provide new income documentation)*

HEALTH INSURANCE

Since your Annual Certification six months ago, has your insurance status changed?

☐ No, there is no change in my insurance status.
☐ Yes, my insurance status has changed. *(Please provide new health insurance documentation)*

Since your Annual Certification six months ago, have you become eligible for employer insurance, or marketplace insurance, or Medicaid, or Medicare?

☐ No, there has been no change in insurance eligibility
☐ Yes, I have become eligible for health insurance *(Please provide new health insurance documentation)*

AGREEMENT

I fully understand that by participating in this program, I am divulging personal information that will be used to assist me with benefits associated with the Denver Ryan White Part A program. I understand this information will be kept confidential but will be used by staff to review my eligibility for this program. Also, by signing this form, I understand that the information contained within may be used to verify all eligibility information provided.

I fully acknowledge:

1. **It is my responsibility to renew my eligibility every six (6) months.**
2. **It is my responsibility to report any changes to my household income, my address, my contact information, my health insurance, or any other information that may affect my eligibility or services.**
3. **If I fail to recertify, my participation in Ryan White Part A funded services may be limited.**

I certify that the information provided in this application is true and accurate as of the date below and acknowledge that any intentional or negligent misrepresentation of the information may result in my inability to receive Ryan White Part A funded services.

Printed Name	Signature	Date