

THIRD AMENDATORY AGREEMENT

This **THIRD AMENDATORY AGREEMENT** is made between the **CITY AND COUNTY OF DENVER**, a municipal corporation of the State of Colorado (the “City”) and **VIVENT HEALTH, INC.**, a Wisconsin Nonprofit Corporation authorized to conduct business in Colorado, whose address is 648 N. Plankinton Ave., Milwaukee, Wisconsin 53203 (the “Contractor”), jointly (“the Parties”).

RECITALS:

A. The Parties entered into an Agreement dated July 12, 2023, an Amendatory Agreement dated September 26, 2024, and a Second Amendatory Agreement dated March 15, 2024 (the “Agreement”) to perform, and complete all of the services and produce all the deliverables set forth on Exhibit A, the Scope of Work, to the City’s satisfaction.

B. The Parties wish to amend the Agreement to increase the maximum contract amount, amend the scope of work exhibit, amend the budget exhibit, update the certificate of insurance exhibit, amend the CMC Service Standards exhibit, and add Exhibit G - Federal Provisions exhibit.

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

1. Section 4 of the Agreement entitled “**COMPENSATION AND PAYMENT:**” subsection d. (1) entitled “**Maximum Contract Amount:**” is hereby deleted in its entirety and replaced with:

“4.d. Maximum Contract Amount:

(1) Notwithstanding any other provision of the Agreement, the City’s maximum payment obligation will not exceed **EIGHT HUNDRED FORTY THOUSAND ONE HUNDRED SIXTY-ONE DOLLARS AND NO CENTS (\$840,161.00)** (the “Maximum Contract Amount”). The City is not obligated to execute an Agreement or any amendments for any further services, including any services performed by Contractor beyond that specifically described in **Exhibit A**. Any services performed beyond those in **Exhibit A** are performed at Contractor’s risk and without authorization under the Agreement.”

2. **Exhibit A, Exhibit A-1 and Exhibit A-2** are hereby deleted in their entirety and replaced with **Exhibit A-3, Scope of Work**, attached and incorporated by reference herein. All references in the original Agreement to **Exhibit A, Exhibit A-1, and Exhibit A-2** are changed to **Exhibit A-3**.

3. **Exhibit B, Exhibit B-1 and Exhibit B-2** are hereby deleted in their entirety and replaced with **Exhibit B-3, Budget**, attached and incorporated by reference herein. All references in the original Agreement to **Exhibit B, Exhibit B-1 and Exhibit B-2** are changed to **Exhibit B-3**.

4. **Exhibit C** is hereby deleted in its entirety and replaced with **Exhibit C-2, Certificate of Insurance**, attached and incorporated by reference herein. All references in the original Agreement to **Exhibit C, Exhibit C-1** are changed to **Exhibit C-2**.

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

6. A new **Exhibit G, Federal Provisions**, is hereby being added to the Agreement.

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

8. This Third 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.

Exhibit List:

Exhibit A-3 – Scope of Work.

Exhibit B-3 – Budget.

Exhibit C-2 – Certificate of Insurance.

Exhibit E-1 – CMC Service Standards.

Exhibit G – Federal Provisions.

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

Contract Control Number: ENVHL-202476413-03 [202368215-03]
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:

REGISTERED AND COUNTERSIGNED:

Attorney for the City and County of Denver

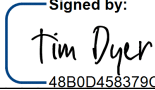
By:

By:

By:

Contract Control Number:
Contractor Name:

ENVHL-202476413-03 [202368215-03]
Vivent Health, Inc.

By:  Signed by:
48B0D458379C482...

Name: Tim Dyer
(please print)

Title: Executive Vice President & CFO
(please print)

ATTEST: [if required]

By: _____

Name: _____
(please print)

Title: _____
(please print)



EXHIBIT A-3 SCOPE OF WORK

I. 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 **Vivent Health, Inc.**

Vivent Health, Inc. has been awarded the following amounts in Ryan White Part A funds:

- Maximum of **\$414,263.00** in Fiscal Year (FY) 2024 (March 1, 2024 – February 28, 2025)

Note: Total Contract Value, \$840,161.00, 03/01/2023 – 02/28/2025.

- Year 1 (03/01/2023-02/29/2024), Amount: \$425,898.00
- Year 2 (03/01/2024-02/28/2025), Amount: \$414,263.00

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 is attached as **Exhibit E-1** and will be updated each fiscal year on an as-needed basis with each fiscal year's updated version as the Service Standards to be followed. The updated version of the Service Standards for FY2024 will be provided no later than March 1, 2024.

B. Vivent Health, Inc. 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:



**EXHIBIT A-3
SCOPE OF WORK**

SERVICE CATEGORY	FUNDING SOURCE	FY2024 1ST AWARD AMOUNT	FY2024 2ND AWARD AMOUNT	FY2024 TOTAL AWARD AMOUNT
Case Management Continuum	RW Part A	\$189,406.00	\$125,885.00	\$315,291.00
Early Intervention Services	RW Part A	\$20,623.00	\$7,941.00	\$28,564.00
Food Bank/Home Delivered Meals	RW Part A	\$4,650.00	\$3,350.00	\$8,000.00
Mental Health Services	RW Part A	\$10,210.00	\$7,743.00	\$17,953.00
Medical Transportation Services	RW Part A	\$7,558.00	\$5,442.00	\$13,000.00
Outpatient / Ambulatory Health Services	RW Part A	\$9,000.00	\$4,755.00	\$13,755.00
Oral Health Care	RW Part A	\$10,300.00	\$7,400.00	\$17,700.00
Total Award Amounts		\$251,747.00	\$162,516.00	\$414,263.00

III. Process and Outcome Measures

Vivent Health, Inc. will provide:

SERVICE CATEGORY	UNDUPLICATED CLIENTS	SERVICE UNITS DELIVERED
Case Management Continuum	426	3200
Early Intervention Services	22	33
Food Bank/Home Delivered Meals	86	172
Mental Health Services	35	384
Medical Transportation Services	98	1500
Outpatient/Ambulatory Health Services	69	122
Oral Health Care	86	110



EXHIBIT A-3 SCOPE OF WORK

IV. Clinical Quality Management Program

A. Clinical Quality Management Plan

1. Contractor will be required to submit their Quality Management Plan to DHR using the template provided by DHR within 30 days of execution of the contract or June 30, 2024, whichever is later.

B. Clinical Quality Management Infrastructure

1. Contractor will be required to identify one contact person for all Quality Management related deliverables and are responsible for informing DHR Quality staff if this changes.

V. Case Management Continuum (CMC) Requirements

- A.** Contractors will be required to follow the CMC Service Standards (**Exhibit E-1**)
- B.** Contractors who are funded for CMC services will also help clients apply for Emergency Financial Assistance, Housing Assistance, Oral Health Fund, and Legal Assistance Fund to clients.
- C.** Contractors who are funded for CMC services will offer all four tiers of the Case Management Continuum (Medical Case Management, Non-Medical Case Management, Care Navigation, and Referral Services)
- D.** 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 will include acuity in their monthly data collection.
- E.** Any staff providing CMC services are required to complete the DHR provided, online, Case Management Certificate Program. Case Management staff who have demonstrated practical experience with the training content may be exempt from taking this training. Contact DHR for additional information regarding the exemption process.
- F.** Contractors will be required to participate in all trainings related to the Case Management Continuum.
- G.** Contractors' staff who are supervisors, managers, and organizational leaders are required to participate in the Trauma Informed Care trainings for Supervisors and Trauma Informed Care for Leaders as provided by DHR.

VI. Invoices and 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.



EXHIBIT A-3 SCOPE OF WORK

Subsequent invoices will be due on the 15th of the second month after the end of the billing period (e.g. September invoice due by November 15th, December invoice due by February 15th, etc.). The final invoice must be submitted by April 15th, 2025.

- 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. Updated invoice forms are provided upon contract execution. A complete invoice package will include the following: a complete invoice template, backup documentation including receipts, payroll printouts, and any supporting documentation needed for all expenses listed on the invoice.
- D.** Complete invoice packages are due to DDPHE HIV Resources at HIVInvoiceIntake@denvergov.org. 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 D-2**.

VII. 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 D-2** 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 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



EXHIBIT A-3 SCOPE OF WORK

survives termination or expiration of this Agreement.

VIII. Administrative Cost Limit

The Contractor's total administrative costs cannot exceed **10%** of the maximum direct costs 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.

IX. Budget

- A.** Contractor shall submit a complete budget package using required DDPHE HIV Resources budget forms. The budget for this agreement is attached as **Exhibit B-3**.

X. Budget Modifications

- A.** Contractor may submit budget modifications to DDPHE for review and approval based on policies established in the Subrecipient Financial Administration attached as **Exhibit D-2**. Approval of such request is based on the discretion of the DDPHE Executive Director or his/her designee.

XI. Performance Management and Reporting

A. Performance Management

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

1. **Clinical Quality Management Plan Monitoring:** Review contractor operation of their Clinical Quality Management program, plan, and activities as documented in the plan,



EXHIBIT A-3 SCOPE OF WORK

- including performance measures data, health outcomes, and client input/feedback.
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 be able to report, upon request, program income directly generated by a supported activity earned as a result of this grant. 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. The Program Income Guidelines are attached as **Exhibit F-2**.
 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.

**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.

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/library/rsr-manual 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 Provider: 15 th of each month PDI: 25 th of each month	Into CAREWare system



**EXHIBIT A-3
SCOPE OF WORK**

	manual data entry via the CAREWare interface; or Provider Data Import (PDI).		
2). Ryan White Part A Service Report (RSR)	Includes, but is not limited to: 1. Data input throughout the year 2. Review finalized CY2023 RSR report with DHR 3. Generate client-level XML (Extensible Markup Language) file for CY2023 and upload into the HRSA Web Application (per HRSA requirement) 4. Submit CY2023 RSR report into HRSA Web Application 5. Run Contractor RSR reports to clean existing data and/or input missing data with technical assistance from DHR	1. Due each month 2. Due by March 20, 2024 3. Due by March 20, 2024 4. Due March 27, 2024 5. Due by February 28, 2025	Into CAREWare system for data entry Into HRSA Web Application for RSR final reporting
3). Other reports, data, or processes as requested by the City	To Be Determined (TBD)	TBD	TBD

XII. 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.

XIII. Required Acknowledgement and Disclaimer Language

- A.** HRSA requires subrecipients to use the following acknowledgement and disclaimer on all products produced by



EXHIBIT A-3 SCOPE OF WORK

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.

Exhibit B-3 Budget

Vivent Health, Inc.

Service Category	Budget Category				Total Budgeted Cost
	Personnel + Fringe	Operating Cost	Other Direct Expenses	Indirect Cost	
CCS	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
CMC-A	\$286,628.68	\$0.00	\$0.00	\$28,662.32	\$315,291.00
CMC-M	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
EIS-A	\$25,967.00	\$0.00	\$0.00	\$2,597.00	\$28,564.00
EIS-M	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
EFA	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
FBM	\$7,273.00	\$0.00	\$0.00	\$727.00	\$8,000.00
HS	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
LS	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
MHS-A	\$16,321.00	\$0.00	\$0.00	\$1,632.00	\$17,953.00
MHS-M	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
MTS	\$8,318.20	\$0.00	\$3,500.00	\$1,181.80	\$13,000.00
OAH	\$12,504.55	\$0.00	\$0.00	\$1,250.45	\$13,755.00
OHC	\$16,091.00	\$0.00	\$0.00	\$1,609.00	\$17,700.00
OHF	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
OPS	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
PSS-A	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
PSS-M	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
SU-A	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
SU-M	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Total	\$373,103.43	\$0.00	\$3,500.00	\$37,659.57	\$414,263.00

TOTAL CONTRACT PERIOD 03/01/2023 - 02/28/2025	Contract Amount	Total Maximum Amount with	TOTAL MAXIMUM AMOUNT
Original Contract 03/01/2023 – 02/28/2024	\$69,026.00	\$69,026.00	
Amendment 01 03/01/2023 – 02/29/2024	\$356,872.00	\$425,898.00	
Amendment 02 03/01/2024 – 02/28/2025	\$251,747.00	\$677,645.00	
Amendment 03 03/01/2024 – 02/28/2025	\$162,516.00	\$840,161.00	\$840,161.00

Exhibit E-1



FY 2024

Service Standards

Ryan White Part A Denver TGA

Revised
January 2023 – January 2024

Approved by the DHRPC
February 1, 2024

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Introduction

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

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

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

Providers are expected to offer effective, equitable, understandable, and respectful quality services that are responsive to diverse experiences, cultural beliefs and practices, languages, learning styles, communication needs, and health literacy levels.

Denver HIV Resources – Part A provider, in partnership with CDPHE, acknowledges that racial, social, economic, and environmental inequities result in adverse health outcomes and have a greater impact than individual choices. Reducing health inequities through systematic change can help improve opportunities for all Coloradans. Ending the epidemic requires us to examine our current HIV service delivery system with the goal of eliminating policies, practices, ideas, and behaviors that do not support equity and allow for service provision that is culturally and linguistically appropriate. Providers should be culturally humble and utilize the strengths of the participants they serve.

This document should be viewed as fluid. The document may change based on Health Resources and Services Administration (HRSA) and HIV/AIDS Bureau (HAB) requirements, the needs of people living with HIV/AIDS in the TGA, and the effectiveness of the services offered by providers. In order to remain responsive, it is imperative that providers, community members, and people living with HIV notify DHR and DHRPC when changes or challenges occur that may impact the relevance and efficiency of this document, or the services provided.

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
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
PLHIV	Person(s) Living with HIV
PVD	Peripheral Vascular Disease
RID	Registry of Interpreters for the Deaf
ROI	Release of Information
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
SDAP	State Drug Assistance Program (formerly known as “ADAP”)
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. 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
<p>A. Provider maintains and disseminates to clients: written client rights and responsibilities.</p>	<p>A.1. Clients are informed of rights and responsibilities through the following:</p> <ul style="list-style-type: none"> • Discussing document with client; • Client will be offered a copy (electronic or hard copy) but may decline; • Client signature of client confirming review and receipt annually; • Posting in a visible location. 	<p>Client’s File contains a signed copy of the client’s Rights and Responsibilities. An electronic signature is acceptable.</p>
	<p>A.2. Client Rights and Responsibilities includes, at a minimum:</p> <ul style="list-style-type: none"> • The client’s expectations of the provider providing services; • Clients are able to access their file and have been informed of how to request access; • The client’s right to file a grievance (see Standard B below); • The client’s right to receive services that are provided in an affirming, inclusive, and accessible environment; • Adding: language access, transportation, etc. • 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; 	<p>Program’s Policies and Procedures contains Client Rights and Responsibilities form.</p>

	<ul style="list-style-type: none"> • The provider expectations of the client as a participant of services • Available in at least English and Spanish. 	
<p>B. Provider maintains and disseminates to clients a written policy for how clients can submit compliments, concerns, and complaints (grievance policy).</p>	<p>B.1. Providers will inform client of grievance policies and procedures through:</p> <ul style="list-style-type: none"> • Discussing document with client; • Client will be offered a copy (electronic or hard copy) but may decline; • Client signature of client confirming review and receipt annually • Posting in a visible location 	<p>Client’s File contains a signed copy. An electronic signature is acceptable.</p>
	<p>B.2. Grievance policy to include, at a minimum:</p> <ul style="list-style-type: none"> • How a client can submit compliments, concerns, and complaints; • How a client can submit concerns or complaints anonymously, • A variety of different options for submitting concerns and complaints (in-person, phone, written, email, etc.) • How submissions will be handled; • What the timeline will be for a client to receive follow up (max. of 14 days following submission of concern, complaint, or grievance) • Include steps that precede a formal grievance such as a conflict resolution process; • The client’s right and how to appeal to DDPHE – DHR; • Available in at least English and Spanish. 	<p>Program’s Policies and Procedures have a process for clients to provide compliments, concerns, and complaints (grievance policy).</p> <p>Program has process for collecting complaints, concerns, and/or compliments outside of formal grievance procedure.</p> <p>Concerns or complaints are a less formal process. Grievances will typically follow a formal internal grievance procedures.</p>
	<p>B.3. Providers must review the grievance policy and procedure</p>	<p>Provider’s Policies and Procedures include a</p>

	<p>annually and update as appropriate.</p>	<p>grievance policy and procedure for review.</p>
	<p>B.4. Providers are responsible for notifying DDPHE - DHR of any formal grievance filed against the provider by a client seeking Ryan White services.</p> <p>Grievances must be reported to DHR at least quarterly and must be submitted to DHR with confidential information redacted as necessary.</p>	<p>Provider's Reports document grievances, including any corresponding documentation as submitted by the client, and the outcome of the grievance.</p> <p>Providers will make available at the DHR Site Visit any other concerns or complaints that have been submitted outside of the formal grievance procedure.</p>
<p>C. Clients are notified about the reasons they are being involuntarily discharged, the process for which discharge is determined, as referrals and support transitioning to other service providers.</p>	<p>C.1. Communication to client must include:</p> <ul style="list-style-type: none"> • reasons they are being involuntarily discharged; • the process for which discharge is determined; • referrals and support transitioning to other service providers <p>If suspension if temporary or permanent and what steps a client would need to take to reengage.</p> <p>Provider will also provide to DHR in the quarterly report a narrative of any customer service-related issues.</p>	<p>Provider's Policies and Procedures show the process for involuntary discharges and how clients are notified.</p> <p>Provider to report to DHR within 10 days that an involuntary discharge has occurred and the supporting documentation.</p> <p>Client Files will document discharge process, referrals made, transition support provided, and how and when client can reengage in services.</p>

II. Confidentiality

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

STANDARD	MEASURE	DATA SOURCE
<p>A. Providers will work with client, to identify their communication preferences, at least annually.</p>	<p>A.1. Agency will create and disseminate a mode of communication preference document.</p>	<p>Client's File will indicate how the client would prefer to be contacted.</p>

<p>B. Provider utilizes Client Release of information form which also describes under what circumstances client information can be released.</p>	<p>B.1. Clients are informed of Release of Information process and what is included at the time of signing an ROI. This should include:</p> <p>Documentation of signed release of information prior to release of records (either electronic or written).</p> <p>ROI must be available in English and in Spanish.</p>	<p>Client’s File contains a signed release of information form with all required elements appropriate to the services provided and information needed.</p>
	<p>B.2. There must be signed and dated ROI prior to the release or exchange of any information.</p> <p>Clients can determine which specific information is included or not included. Form must specify HIV, TB, STI, substance use, mental health and any other confidential information that is needed to provide the service.</p>	<p>Client’s File contains a signed release of information form with all required elements appropriate to the services provided and information needed.</p>
<p>C. Providers shall have written policies and procedures addressing client confidentiality, privacy, and the use of a release of information form.</p>	<p>C.1. Written policies and procedures address include:</p> <ul style="list-style-type: none"> • Compliance with state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA), when applicable; • Storage of client records, including double lock with access limited to appropriate personnel retaining client records, as well as for destroying records that pass the retention date; • Protection of electronic client records through the use of encryption, passwords, screen savers/privacy covers, or other mechanisms; • Availability of private, confidential meeting space; • Measures to address suspected breaches of confidentiality. 	<p>Provider’s Policies and Procedures include a copy of the ROI, confidentiality, and privacy policies.</p> <p>ROI policy is publicly posted.</p>

	<p>C.2. Confidentiality, Privacy, and ROI Policies and Procedures are signed and dated by staff during orientation.</p>	<p>Personnel file has a signed statement by each staff that the staff has read and understood the provider's policies and procedures regarding confidentiality.</p>
	<p>C.3. Changes in policies and procedures are presented to all the staff they impact.</p>	<p>Personnel file indicates that staff have been trained on any changes to policies and procedures that impact implementation of the policy.</p>
	<p>C.4. Provider will have an annual HIPAA training for employees.</p>	<p>Provider Policies and Procedures show documentation of annual HIPAA training.</p>
<p>D. All records and hard copy materials shall be securely maintained by the Provider.</p>	<p>D.1. Records and hard copy materials are maintained under double lock (in locked files and in locked areas), secure from public access.</p>	<p>Site Visit observation.</p>
	<p>D.2. Each computer is password protected and staff/volunteers must change passwords at least every 120 days.</p>	<p>Provider's Policies and Procedures on confidentiality demonstrate compliance.</p>
<p>E. Provider must have a private space or appropriate accommodations to conduct confidential client meetings.</p>	<p>E.1. The provider 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.)</p>	<p>Site Visit inspection of provider's facility.</p>
<p>F. Providers must have a policy for retaining client records, as well as for destroying records that are past the retention date.</p>	<p>F.1. Records must be stored and accessible for a period of seven years after the closing of the case. After the seventh year, records can be destroyed. Destroying documents must be done in a way that will maintain confidentiality.</p>	<p>Provider's Policies and Procedures on file retention demonstrate compliance</p>

III. Eligibility

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.

Thorough documentation is preferred, but Providers can use self-attestation, if needed

STANDARD	MEASURE	DATA SOURCE
<p>A. Services are available to all eligible clients.</p> <p>Eligible clients include people living with HIV who are at or below 500% FPL and reside in the Denver TGA.</p>	<p>A.1. Providers should periodically review eligibility guidelines to ensure that they are consistent with contracts and the Part A Service Standards.</p> <p>Providers should actively inform clients on how to access services.</p>	<p>Provider's Policies and Procedures has on file documentation of eligibility criteria, consistent with the Service Standards and other guidelines established by DHR.</p>
<p>B. Every provider must have the ability to screen clients RW Part A eligibility.</p>	<p>B.1. Providers will have an eligibility procedure.</p>	<p>Provider's Policies and Procedures include a procedure on eligibility screening process.</p>
	<p>B.2. Providers must have the necessary staff and systems for screening procedure.</p>	<p>Provider's Policies and Procedures demonstrate the necessary staff and systems for screening procedure.</p>
	<p>B.3. Document that all staff involved with eligibility determination have participated in a comprehensive, internal or external training in eligibility determination requirements.</p>	<p>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.</p>
<p>C. Every client's legal name will be documented and used in the creation of the eURN in CAREWare. And every client's chosen name and pronouns</p>	<p>C.1. Providers are to use the client's legal name attained from a government issued document in data entry in CAREWare.</p>	<p>Client's File contains copy of a government issued document showing legal name (e.g., driver's license, social security card, matricula card, and/or passport).</p> <p>This must be confirmed at initiation of services.</p>

<p>are documented and utilized by staff.</p>	<p>C.2. Ensure provider’s client level data reporting is consistent with funding requirements including RSR data elements, and demonstrates that eligible clients are receiving allowable services.</p>	<p>Client’s File and CAREWare Data demonstrate that client receives only allowable services.</p>
	<p>C.3. Client’s chosen name and pronouns are documented in the client’s file and utilized during visits</p>	<p>Client’s File will document that the client has provided their chosen name and pronouns.</p>
<p>D. Payer of Last Resort (PoLR): Providers will ensure that Ryan White Part A funds are used as PoLR for eligible services and eligible clients.</p>	<p>D.1. Providers will have written policies and procedures for ensuring that Ryan White Part A funds are used as a PoLR for eligible services and eligible clients.</p>	<p>Provider’s Policies and Procedures will have policy and procedure regarding payer of last resort.</p>
<p>E. Providers will ensure appropriate screening and assessment of client eligibility every 12 months.</p>	<p>E.1. Providers will recertify eligibility every 12 months. Providers will document:</p> <ul style="list-style-type: none"> • Verification of continued residency within the TGA • Client household income is at or below 500% of FPL • Client is not eligible for third party payer by screening each client for: • Insurance coverage and Ryan White eligibility <p>Insurance coverage and eligibility for third party programs, and assist the client to apply for such coverage, and assist the client to apply for such coverage</p>	<p>Client’s File will document all updates to client’s eligibility every 12 months when recertification should occur.</p> <p>It is recommended that eligibility align with SDAP and is collected at the client’s birth, however, this is not required.</p> <p>At least once a year (whether defined as a 12-month period or calendar year). Providers must collect verification of an individual’s income, residency, and insurance status.</p> <p>**Please note: client’s original certification should happen within 30 days of enrollment in services.</p>
<p>F. Proof of HIV Status: Providers will verify and document individuals seeking services, of their HIV</p>	<p>F.1. Verification of the client’s HIV status should be from a medical program.</p>	<p>Client’s File will contain documentation of their HIV status. This only needs to be verified when a client initiates services.</p>

<p>status, at initial determination only.</p>		<p>Acceptable forms of verification include:</p> <ul style="list-style-type: none"> • CAREWare Shared Eligibility Information • Lab work results (from EMR, copy sent by clinic, etc.) • A letter on letterhead sign by medical staff personnel • Current SDAP card or confirmation of application/renewal • CAREWare lab data
<p>G. Proof of Income: Providers will verify and document that individuals receiving services meet income level guidelines.</p> <p>Providers should follow set criteria to include or exclude people when computing the client's household size.</p>	<p>G.1. Client must qualify as low income; a household income of less than or equal to 500% of FPL.</p> <p>Household income is what the client defines as their household.</p> <p>People who meet the following criteria should be included when computing the household size of the client:</p> <ul style="list-style-type: none"> • 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. 	<p>Client's File will contain documentation of the client's income. This should be verified every 12 months.</p> <p>Acceptable forms of verification may include:</p> <ul style="list-style-type: none"> • CAREWare Shared Eligibility Information; • One month's worth of paystubs; • Bank statement within the last 30 days; • Current SDAP card; • Confirmation of SDAP application/renewal (verification through documentation, Ramsell and/or CAREWare); • AND/SSI/SSDI award letter; • Medicaid card or proof of Medicaid coverage <p>If the client is reporting no income or is unable to provide proof of income, they may provide self-attestation.</p>
<p>H. Proof of Insurance: Providers will verify and document individuals seeking services insurance status.</p>	<p>H.1. Clients will demonstrate insurance status including:</p> <ul style="list-style-type: none"> • Uninsured status; • Determination of eligibility and enrollment in other third-party insurance programs 	<p>Client's File will contain documentation of the client's insurance. This should be verified every 12 months.</p>

	<p>including Medicaid and Medicare;</p> <ul style="list-style-type: none"> • Clients receiving VA or Indian Health Services benefits are exempt from the “payer of last resort” requirement. 	<p>Acceptable forms of verification include:</p> <ul style="list-style-type: none"> • CAREWare Shared Eligibility Information • Copy of dated insurance card or statement of coverage; • Current SDAP card • Confirmation of SDAP application/renewal • SSI/SSDI award letter if insurance is listed <p>If the client is reporting no insurance, then the Provider will utilize an approved Insurance Screening attestation.</p>
<p>I. Proof of Residency: Providers will verify and document individuals seeking services are residents of the Denver TGA, composed of Adams, Arapahoe, Broomfield, Denver, Douglas, and Jefferson counties.</p>	<p>I.1. Providers will document verification of residency within the TGA as part of the initial and annual eligibility process.</p>	<p>Client’s File will contain documentation of the client’s residency. This should be verified every 12 months.</p> <p>Acceptable forms of verification include:</p> <ul style="list-style-type: none"> • CAREWare Shared Eligibility Information • An unexpired Colorado driver’s license or state-issued identification card with a current valid TGA address; • A lease mortgage, rent receipts, hotel receipts, or other evidence that the client has obtained and/or paid for housing within the TGA; • A utility bill with a TGA service address in the client’s name; • Another form of government-issued identification or documentation (i.e., benefits statement) with a valid TGA residential address. • Medicaid card (with proof of residence in the Denver TGA) • SDAP (formerly known as ADAP) enrollment verification; Medication and Medical Copay Assistance

		<p>Identification Care (Denver TGA indicated by letter “M” on back of SDAP card)</p> <ul style="list-style-type: none"> • Ramsell face sheet; • Medication and Medical Copay Assistance Identification Card. <p>In certain instances, a client may be unable to produce one of the preferred forms of documentation of TGA residency due to homelessness, undocumented status, or other barriers. In such instances, acceptable forms of documentation may include:</p> <ul style="list-style-type: none"> • A signed letter from a person with whom the client resides or who otherwise provides housing for the applicant, verifying the clients’ residence in the Denver TGA. • A signed letter from a case manager or other professional explaining why the client’s claim of Denver TGA residency is supportable. • 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.
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VI. 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.

Denver HIV Resources – Part A provider, in partnership with CDPHE, acknowledges that racial, social, economic, and environmental inequities result in adverse health outcomes and have a greater impact than individual choices. Reducing health inequities through systematic change can help improve opportunities for all Coloradans. Ending the epidemic requires us to examine our current HIV service delivery system with the goal of eliminating policies, practices, ideas, and behaviors that do not support equity and allow for service provision that is culturally and linguistically appropriate. Providers should be culturally humble and utilize the strengths of the participants they serve.

Providers 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. “Translation Services” refer to written services.)

STANDARD	MEASURE	DATA SOURCE
<p>A. Services are provided in an affirming, inclusive, and accessible environment.</p> <p>Clients are given information about section A when they start services with the provider.</p>	<p>A.1. Providers will update policies, practices, and procedures, as needed, to address barriers to accessing services.</p>	<p>Provider’s Policies and Procedures document how they will be ensuring access and addressing barriers are on file and reviewed and updated annually.</p> <p>Providers will document client requests for modifications/accommodations and what actions were taken to accommodate such requests.</p> <p>Examples include:</p> <ul style="list-style-type: none"> • Adopting and implementing the National Standards for Culturally and Linguistically Appropriate Services (CLAS) as relevant to their provider. • Updating a policy about how intakes to services are completed, including asking clients if they need any help or accommodation during their visit and documenting it in their file • Granting earlier or later appointments for clients with anxiety so that fewer people will be in the office and the noise will be minimal • Client’s chosen name and gender pronouns are documented in the client’s file and utilized during visits • Creating a kid-friendly environment, including toys, children’s books, and kid-sized furniture in the waiting room • Offering evening and weekend office hours to

		<p>accommodate clients who can't make an appointment Monday through Friday</p>
	<p>A.2. Providers will ensure whatever is written or spoken is clear and understandable, and in the client's preferred language.</p> <p>Providers will notify clients of their right to receive free language assistance services, in their preferred language, and this will be posted in a visible location.</p>	<p>Provider's Policies and Procedures will include procedures about language and literacy accommodations. Providers document language assistance requests.</p> <p>This includes:</p> <ul style="list-style-type: none"> • Written documents are available in multiple languages • Translation services are available, at no added cost • Providing information at an appropriate comprehension level • Websites are easy to access and can be used by screen reading technology <p>Providers are trained in different ways to communicate, including:</p> <ul style="list-style-type: none"> • the need to repeat the message so clients understand, • using visual aids to communicate health information
	<p>A.3. Family and friends are not considered adequate substitutes for interpreters because of confidentiality, privacy, and medical terminology issues.</p> <p>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.</p>	<p>Client's File contains signed consent form that requests family member or friend to provide interpretation services.</p>
	<p>A.4. Providers will ensure that their facilities are accessible,</p>	<p>Site Visit inspection of provider's facility. Facilities</p>

	<p>and any accommodation provided is documented.</p>	<p>meet the Americans with Disability (ADA) standards, or appropriate accommodations are made.</p> <p>Examples include:</p> <ul style="list-style-type: none"> • Wheelchair accessible restroom with clear turning space, grab bars and accessible sinks • Braille signage at office, elevator, and restroom doors, as applicable
	<p>A.5. Facilities are easy to find and get to.</p>	<p>Program’s Policies and Procedures should include the following:</p> <ul style="list-style-type: none"> • ADA compliance with accessible parking options (which could include curb ramps, designated disability parking, or loading zones) • The facility is close to public transportation (ideally within .5 miles) and bus route information is available to clients • Transportation assistance availability information • Free parking options close to facility • Remote/tele-health options are available
	<p>A.6. Providers will keep updated office hours and inform clients of how to access after-hours care.</p> <p>And, if possible, after-hours services are available to meet client needs.</p>	<p>Provider’s Policies and Procedures will include procedures describing how to client’s access emergency services after business hours and during unscheduled closings.</p> <p>Information on regular business hours and closures should be readily accessible and publicly available, including:</p> <ul style="list-style-type: none"> • In a prominent place within the facility

		<ul style="list-style-type: none"> • On the provider’s website and voicemail
<p>B. Provider will have informational materials to inform individuals of HIV-related services and how to access them.</p>	<p>B.1. Availability of informational materials about the agency’s services and eligibility requirements, such as:</p> <ul style="list-style-type: none"> • Newsletters • Brochures • Posters • Community Bulletins • Any other type of promotional materials <p>Materials will be culturally and linguistically appropriate.</p>	<p>Providers will have documentation of activities that promote information related to the availability and access of HIV services as well as referral relationships and linkage agreements with key points of entry.</p> <p>Providers must maintain a file documenting agency activities for the promotion of HIV services to individuals, including copies of HIV program materials promoting services and explaining eligibility requirements.</p>
<p>C. Providers assure that waiting times for initial appointments and during service delivery are reasonable, based on existing resources.</p>	<p>C.1. Providers will monitor wait times for all funded services.</p>	<p>Program’s Files will document appointment systems, client satisfaction surveys, or other methods of verification.</p>
<p>D. When a new or existing client requests a service, the provider will offer a list of resources and other HIV service providers.</p>	<p>D.1. All clients will be provided with a current list of other providers offering the same services, as well as resources outside of the Part A system.</p> <p>For additional information please refer to Program Guidance 06272022</p>	<p>Providers must maintain a file of current HIV service providers and other resources available to clients. This file should be updated annually.</p> <p>Program’s Policies and Procedures will have a written policy and procedure detailing how and when clients are provided with information about other service providers and resources.</p>
<p>E. Providers must have policies and procedures in place that describe how they will maintain client waiting periods that are longer than 2 weeks (should include policy for maintaining waitlists and</p>	<p>E.1. During the waiting period and if a client is added to a waitlist, clients must be informed of other agencies who are accepting clients for that particular service.</p>	<p>Program’s Files will have written documentation of appointment systems, client satisfaction surveys, or other methods of verification.</p> <p>Client’s File include documentation that waitlist information was communicated.</p>

<p>referring clients to other agencies).</p>		<p>Program’s Policies and Procedures detail how long waiting periods of 2 weeks or longer (waitlists) will be managed.</p>
<p>F. Providers 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.</p> <p>Clients who will need to wait longer than two weeks for services or are put on a waitlist will also be offered a referral to another organization.</p>	<p>F.1. Program has a referral and linkage system in place including referral procedures and a system to track completed referrals.</p>	<p>Program’s Files will have written documentation of linkage procedures, linkage agreements, or documentation of referrals and linkage outcomes.</p>
	<p>F.2. To establish this base of referrals, providers need to network with other community-based HIV organizations and prevention providers as well as city, state, and private organizations providing similar or complimentary services in the community.</p>	<p>Provider’s policies and procedures demonstrate that the provider has established a full range of service referrals and maintains effective referral relationships with other providers.</p>
	<p>F.3. Providers should make an active referral, or a passive referral based on the client’s situation, preference, and need.</p> <p>Active referrals require referring agency to support the client in getting connected to the new organization and includes contacting the client to ensure they were connected to services. It may also include contacting the new organization to get the new client connected.</p> <p>Passive referrals require the referring agency to provide the client with the contact information for the new organization.</p>	<p>Program’s Policies and Procedures demonstrate that the provider has processes for making active and passive referrals.</p>
<p>G. Programs have a process for staffing transition which is designed to minimize possible adverse effects to the clients and should include how clients will be informed.</p>	<p>G.1. Staffing transitions should be communicated to clients for services that require them to be connected to a specific provider. This will include:</p> <ul style="list-style-type: none"> • Notification that provider is leaving and what their last 	<p>Client’s File contains documentation of:</p> <ul style="list-style-type: none"> • Contact method(s) used; • What was included in the communication;

	<p>day is (this can be in email, letter, phone call, or text message)</p> <ul style="list-style-type: none"> • Why reassignment was necessary; and • Contact information about the person the client will be working with. <p>Program Supervisors should review and ensure process is followed and be prepared to answer any client concerns.</p> <p>When clients cannot be notified in a timely manner Supervisors will ensure clients are notified and client files are updated.</p> <p>For additional information please refer to Program Guidance 06272022</p>	<ul style="list-style-type: none"> • If client had any concerns and what actions taken to address those concerns; <p>If contact attempts made were not received.</p>
	<p>G.2 Programs have a policy and procedure describing how staffing transitions will be managed, including how clients will be notified and what timeline notification will occur.</p>	<p>Program’s Policies and Procedures document the process of how clients will be communicated with and what the follow up procedure is.</p>
<p>H. Services are provided to eligible clients regardless of an individual’s ability to pay for the service.</p>	<p>H.1. Providers will have a sliding scale fee that is consistent with state and federal guidelines.</p> <p>Provider 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.</p> <p>Billing and collection policies and procedures do not:</p> <ul style="list-style-type: none"> • Deny services for non-payment; 	<p>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.</p>

	<ul style="list-style-type: none"> • Require full payment prior to service; • Include any other procedure that denies services for non-payment 	
	<p>H.2. Providers will have sliding scale fee that is consistent with state and federal guidelines. Sliding fee scale details are below.</p> <p>Individual Income Maximum Charges:</p> <ul style="list-style-type: none"> • For clients at or below 100% of Poverty - \$0; • For clients at 101% to 200% of Poverty - No more than 5% of gross annual income; • For clients at 201% to 300% of Poverty No more than 7% of gross annual income; For clients over 300% of Poverty No more than 10% of gross annual income. <p>These limits shall apply only to agencies that impose any level of charges for services.</p>	<p>Program’s Policies and Procedures will have sliding scale policy.</p> <p>Providers will develop policy and procedures for a sliding scale fee that is consistent with state and federal guidelines including:</p> <ul style="list-style-type: none"> • 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 his/her annual cap.
<p>I. Provider will make HIPAA-compliant virtual services available to all RWHAP Part A clients.</p>	<p>I.1. Provider will ensure that clients have the option to receive services via HIPAA-compliant virtual platforms if a service can be provided online.</p>	<p>Program’s Policies and Procedures demonstrate that tele-health services are offered to clients, when applicable.</p>
	<p>I.2. Provider will have procedures in place that give clients the right to accept virtual services or deny virtual services and request meeting with a provider in person.</p>	<p>Program’s Policies and Procedures show that clients have a right to accept or deny virtual services and to see a provider in person upon request.</p>

V. Quality Management & Capacity Building

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
<p>A. Each program will have written policies on Quality Management, including how data will be used to improve each funded program.</p>	<p>A.1. Each program will collect client level data to support CAREWare reporting and other data reports as indicated.</p>	<p>Reports from Denver HIV Resources will be completed accurately and on time.</p>
	<p>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.</p>	<p>Program's Reports documents the use of a quality improvement system.</p>
<p>B. Providers will have a quality plan (using the DHR Quality Plan Template) including all initiatives for required performance measures (core and support).</p>	<p>B.1. Providers will have a quality plan to assess the quality of care provided, to ensure that inequities are identified and addressed, and to identify areas for improvement.</p>	<p>Program's Reports documents the use of a quality plan.</p>
	<p>B.2. Quality plan is updated annually.</p>	<p>Program's Reports document quality plan revisions.</p>
<p>C. Providers will document clinical quality management activities, and meetings, including at least one quality improvement project focused on evaluating or improving HIV program services.</p>	<p>C.1. Quality improvement projects must be focused on improvement of health outcomes along the HIV Care Continuum.</p>	<p>Program's Files and Reports document quality management activities.</p>
<p>D. Providers will assure compliance with relevant service category definitions and Denver transitional grant area (TGA) service standards.</p>	<p>D.1. Providers will conduct quality assurance activities as needed to comply with Denver TGA service standards.</p>	<p>Program's Files and Reports document quality assurance activities.</p>
<p>E. Providers will involve people living with HIV in quality improvement efforts.</p>	<p>E.1. Providers will involve people living with HIV in one or more of the following ways: with surveys, focus groups, review of grievances filed, or key informant interviews, presentations,</p>	<p>Program's Quality Plan documents how clients are included in quality improvement efforts.</p> <p>A copy of the survey, interview questions, presentation, agenda for community advisory boards and/or</p>

	and feedback from a community advisory board and/or as members of a quality improvement committee.	quality improvement committee roster is available for review.
F. Program will implement structured and ongoing efforts to obtain input from clients regarding the design and delivery of services, including policies and procedures.	F.1. 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.
G. Agency uses internal data to identify inequities in health outcomes and service delivery among clients served and changes policies and/or practices to address inequities.	G.1. Agencies will: <ul style="list-style-type: none"> • Collect and analyze data related to equity of service delivery and health outcomes; • Identify projects or changes in policies that will impact inequities; • Measure impact of changes made 	Program’s files show how data is used to measure equity of services and health outcomes, as well as changes in policies and procedures as a result of this data. Program’s Quality Plan documents equity efforts and has related action items.
H. Providers will use client grievances, complaints, concerns, and/or compliments to inform quality improvement activities.	H.1. Provider demonstrates that there is a process to include feedback provided by clients in quality improvement activities.	Program’s Files document client grievances, complaints, concerns, and/or compliments and how these are being used in quality efforts.

VI. Staff and Volunteer Requirements and Training

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

STANDARD	MEASURE	DATA SOURCE
A. Providers recruit, retain, and promote a diverse staff and leadership that reflects the cultural lived experience and linguistic diversity that is reflective of the communities being served.	A.1. Providers have a strategy on file to recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.	Provider’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.

	<p>Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.</p>	<p>Job descriptions contain language that prioritizes diverse hiring practices.</p>
<p>B. Supervisors will provide structured supervision to staff.</p>	<p>B .1. Every supervisor will provide supervision to employees working directly with clients.</p> <p>Supervision may include the following:</p> <ul style="list-style-type: none"> • Support in personal and professional development • Support in knowledge, and skill building • Adequate resources to do the work • Trauma Informed Care skills • Ethical practices • Burnout and stress 	<p>Program’s Policies and Procedures include documentation regarding supervision practices.</p> <p>Personnel Files include documentation of staff supervision meetings, and any action items or outcomes.</p>
<p>C. Staff and supervisors are qualified to provide the necessary services to clients.</p>	<p>C.1. Staff and Supervisors have the appropriate licensure, education and/or experience, as required by the position.</p>	<p>Personnel file has proof of licensure and/or education appropriate for the specific position.</p>
<p>D. Initial orientation and training shall be given to new staff.</p>	<p>D.1 Newly hired staff are oriented as soon as possible, and within 30 days of employment on the following:</p> <ul style="list-style-type: none"> • Cultural responsiveness • Basic HIV information including medical and support services • Confidentiality and disclosure <p>Newly hired staff are oriented as soon as possible and within 6 months of employment on the following:</p> <ul style="list-style-type: none"> • Program's policy and procedures 	<p>Personnel File demonstrates the type, amount (minutes or hours), and date of orientation and training that each staff receives both internally and externally.</p>

	<ul style="list-style-type: none"> • Ryan White (RW) Care Act Part A services and other funding sources • Other government and community programs • Behavioral health services and support • Denver TGA Part A service standards and requirements • Data collection and methodologies <p>Training can be internal and external to the organization.</p>	
<p>E. Providers will ensure that clients receive, from all staff members, responsive, equitable, understandable, respectful, and quality care that is provided in a manner compatible with the client’s cultural beliefs, practices, communication style, and experience.</p> <p>Providers should use a client centered approach to delivering services.</p>	<p>E.1. All staff members receive appropriate diversity, equity, and inclusion training within the first year of employment and at least annually thereafter.</p>	<p>Program’s Policies and Procedures contain requirements for diversity, equity, and inclusion training for all staff members.</p> <p>Personnel files demonstrate the type, amount (minutes or hours), and date of training that each staff receives both internally and externally.</p>
<p>F. Staff should receive the following training annually.</p>	<p>F.1. Every staff handling confidential information will receive an annual training concerning HIPAA, confidentiality, and disclosure.</p>	<p>Personnel file demonstrates the type and amount of training each staff received both internally and externally.</p>
	<p>F.2. Every staff receives annual training on Occupational Safety Health Administration regulations and universal precautions.</p>	<p>Personnel file demonstrates the type and amount of training each staff received both internally and externally.</p>
	<p>F.3. Every direct care staff receives 20 hours of job specific professional development training annually.</p>	<p>Personnel file demonstrates the type and amount of training each staff received both internally and externally.</p>

<p>G. Each program has a volunteer training program appropriate to support each volunteer position.</p>	<p>G.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:</p> <ul style="list-style-type: none"> • Cultural responsiveness • Basic HIV information • Basic client contact skills • HIPAA, confidentiality, and disclosure • Program's policy and procedures <p>Training can be internal and external to the organization.</p>	<p>Volunteer file demonstrates the type and amount of orientation the volunteer received.</p>
<p>H. Staff or volunteers working with clients are to be screened in accordance with state and local laws.</p>	<p>H.1. Background checks must be obtained as required by state and local laws.</p>	<p>Personnel or Volunteer file contains background checks.</p>
<p>I. Staff or volunteers transporting clients will have a valid Colorado driver's license and proof of insurance.</p>	<p>I.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.</p>	<p>Personnel or Volunteer File contains a copy of a valid driver's license for those staff or volunteer who transport clients.</p>

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, retention, and 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 to access services	Responsive Need/Want for episodic support to access 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 intake¹ Reassessed at least annually. May be face to face, virtual, phone, or email.
Service Plan	Required The Service Plan is updated when: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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 of service.

¹ However, brief assessment is allowed.

CORE ELEMENTS	MEDICAL CASE MANAGEMENT	NON-MEDICAL CASE MANAGEMENT	CARE NAVIGATION	REFERRAL FOR SERVICES
Access to and coordination with medical care	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Client reports on ability to self-manage care. • Assistance with coordination is provided upon request. 	Not Required	Not Required
Adherence	<ul style="list-style-type: none"> • 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 any time, 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 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 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.

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, retention, and 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:

- **SDAP** 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

1 unit = 15 minutes or less

Service Components

STANDARD	CRITERIA	DOCUMENTATION
Initial Assessment		
<p>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.</p>	<p>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.</p>	<p>Client’s File should document eligibility in terms of Denver TGA residency, HIV status, and income, as described in the Universal Standards.</p> <p>The client record should also document:</p> <ul style="list-style-type: none"> • 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

		<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • Client rights and responsibilities • Client grievance procedure • Information on confidentiality
<p>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.</p>	<p>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:</p> <ul style="list-style-type: none"> • The level of case management complexity • The frequency of contact • The complexity of the provider’s overall caseload 	<p>Client’s File should contain a completed assessment form in the client record covering the following:</p> <ul style="list-style-type: none"> • 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

		<p>updated as needed</p> <p>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 (Use) & Mental Illness Symptom Screener (SAMISS) and the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) which is used in the context of SBIRT.</p>
<p>C. Medical case management services should be responsive to the current situation of the client.</p>	<p>C.1. Reassessment of the client's needs is conducted as needed, but not less than once every six months.</p>	<p>Client's File documents reassessments.</p>

Service Planning

<p>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.</p> <p>Clients should receive medical case management that is centered on their needs and based on client priorities.</p>	<p>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:</p> <ul style="list-style-type: none"> ▪ 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 	<p>All service plans are entered and updated in the agency's data system. Service plan written in a SMART format indicates:</p> <ul style="list-style-type: none"> • Goals • Action steps • Actual outcomes • Changes or updates • Follow up <p>At least one goal in the service plan should address health and wellness related to HIV, such as barriers, adherence, or medical care.</p>
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	<p>resources /they have?</p> <ul style="list-style-type: none"> ▪ 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? 	
<p>E. The provider and client will work together to decide a timeline and who will take responsibility for each task.</p>	<p>E.1. A reasonable timeline is determined for achievement of goals, with tasks assigned to either provider or client.</p>	<p>The service plan indicates the individual responsible for each task:</p> <ul style="list-style-type: none"> • Provider (ex. Case Manager) • Client • Family or support • Other staff or agency <p>The Service Plan indicates anticipated time frame for each task.</p>
<p>F. Reassessment is completed as needed, but not less than once every six months.</p>	<p>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 every six months when reassessment occurs.</p>	<p>Provider will document all updates to the service plan upon achievement of goals, when other issues or goals are identified, or at least every six months, when reassessment should occur.</p>
<p>G. Medical case management should be relevant to the client’s current situation.</p>	<p>G.1. The strategy or plan of action should be consistent with the updated service plan including:</p> <ul style="list-style-type: none"> • 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 	<p>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:</p> <ul style="list-style-type: none"> • Progress made towards service plan and action taken to overcome barriers

	<p>access services</p> <ul style="list-style-type: none"> • Negotiation and advocacy as needed • Other case management activities as needed 	
<p>H. Determination of the need for service plan revision.</p>	<p>H.1. Provider will revise service plan as changes in client circumstances warrant.</p>	<p>Client's File documents all updates to the service plan.</p>
<p>Referrals and Care Coordination</p>		
<p>I. Provider will provide referrals, advocacy, and interventions based on the service plan.</p>	<p>I.1. Providing a referral may include:</p> <ul style="list-style-type: none"> • 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 any barriers to completing goals in the service plan 	<p>Client's File includes ongoing documentation of the following:</p> <ul style="list-style-type: none"> • 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
<p>J. Each client receiving medical case management services will receive referrals to those services critical to achieving optimal health and well-being.</p>	<p>J.1. The provider will support the client to initiate referrals that were agreed upon by the client and the provider. Referrals include:</p> <ul style="list-style-type: none"> • Referral to a named agency • The name of a contact person at the referral agency • An exact address 	<p>Client's File documents All of the elements of referral.</p>

	<ul style="list-style-type: none"> • Specific instructions on how to make the appointment • Identifying referral agency eligibility requirements • What to bring to the appointment. 	
<p>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.</p>	<p>K.1. Signed release of information forms are obtained as necessary.</p>	<p>Client’s File contains signed release(s) of information, when necessary.</p>
<p>L. Each client will receive assistance to help problem solve when barriers impede access.</p>	<p>L.1. The provider will work with the client to identify barriers to referrals and assist in finding culturally responsive solutions to address barriers.</p>	<p>Client’s File documents all barriers identified in referral process and the actions taken to resolve them.</p>
<p>M. The provider will ensure clients are accessing needed referrals.</p>	<p>M.1. The provider will utilize a tracking mechanism to monitor completion of all referrals.</p>	<p>Client’s File documents follow-up activities and outcomes.</p>
<p>N. Providers shall maintain communication with client’s primary care provider.</p>	<p>N.1. Providers will make contact with a client’s primary care clinic at a minimum of twice a year, or as clinically indicated.</p>	<p>Client’s File must include:</p> <ul style="list-style-type: none"> • 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 <p>It is strongly preferred that this clinical data be reported directly from the medical provider and not rely on client self-report.</p>

<p>O. Clients who are not engaged in care should be referred to a primary care physician.</p>	<p>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.</p>	<p>Client’s File contains evidence 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.</p> <p>Referral should be documented in client file.</p>
<p>P. Case reviewing utilized as a specific mechanism to enhance case coordination.</p>	<p>P.1. Interdisciplinary case review should be held for each client at least annually, or more often if clinically indicated.</p>	<p>Client’s File provides evidence of timely case reviewing with key providers is found.</p> <p>Case reviews may take place face-to-face, by phone, or electronically. This may involve clients operating as a “go between” with the provider.</p>
<p>Adherence Planning</p>		
<p>Q. Adherence should be assessed and then discussed with the client. Any needed Adherence plan should be developed concurrently and collaboratively with the client.</p>	<p>Q.1. The adherence plan should address both medical and non-medical needs and reflect compliance of adherence counseling standards of care.</p>	<p>The written adherence plan in the client record should, strive to include:</p> <ul style="list-style-type: none"> • 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 use counseling • Relapse prevention and management strategies • Other practical strategies that support adherence
<p>Transition/Case Closure</p>		
<p>R. At the conclusion of medical case management services, the client’s goals should have been met and, when appropriate, there</p>	<p>R.1. Clients should demonstrate one of the medical case management case closure criteria.</p>	<p>Client’s File should demonstrate one or more of the following case closure criteria being met:</p> <ul style="list-style-type: none"> • Successful completion of all the goals in the service plan

<p>should be a seamless transition to less intensive case management services (such as non-medical case management or care navigation) or case closure.</p>		<ul style="list-style-type: none"> • 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 to locate after multiple attempts, etc.) • Client demonstrates the ability to independently manage their care in a sustainable manner <p>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</p>
<p>S. The Provider will complete a transition/case closure summary.</p>	<p>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.</p>	<p>Transition/case closure summaries will include:</p> <ul style="list-style-type: none"> • 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 <p>Reasons for case closure and criteria for re-entry into services</p>
<p>Confidentiality/Documentation</p>		
<p>T. Case management records will reflect compliance with the case management standards of care. Records should be complete, accurate,</p>	<p>T.1. All client record progress notes will document the date, the type of encounter, and description of the encounter.</p> <p>Transportation of client records should be handled only by</p>	<p>There is one record per client. Each client record entry includes:</p> <ul style="list-style-type: none"> • Date of client visit/contact, • Reason for visit/contact, • Any activities performed,

<p>confidential, and secure.</p>	<p>authorized personnel and in a manner to ensure security and confidentiality.</p>	<ul style="list-style-type: none"> • Outcome plan, and • Follow-up
<p>Staff Qualifications</p>		
<p>U. Medical case management staff should be appropriately qualified and trained.</p>	<p>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.</p> <p>Medical case management staff will have a one-year period starting on their date of hire to document their qualifications.</p>	<p>Personnel Records should document qualification of providers by the following means:</p> <ul style="list-style-type: none"> • 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). <p>This is in addition to the required trainings outlined in the Universal Service Standards.</p>
<p>V. Medical case management staff should receive appropriate supervision.</p>	<p>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.</p> <p>Supervisory files should document supervisory activities, including direct observation of services, follow up actions, and effort to improve service quality.</p>	<p>Personnel Records should document qualifications of direct supervisor of providers.</p> <p>Supervisory files should contain the following:</p> <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> ○ Completion of the MCM Certificate Online Training (available through DHR). ○ Evidence of training or quality improvement activities ○ Evidence staff received supervision

		<ul style="list-style-type: none"> ○ 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’s 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 provide 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

- 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:

- **SDAP** 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

1 unit = 15 minutes or less

Service Components

STANDARD	CRITERIA	DATA SOURCE
Initial Assessment		
<p>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</p>	<p>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 no later than two weeks after initial contact.</p>	<p>Client’s File should document eligibility in terms of Colorado residency, HIV status, and income, as described in the Universal Standards.</p> <p>The client record should also document:</p> <ul style="list-style-type: none"> • Date of intake • Source of referral

<p>case management service.</p>		<ul style="list-style-type: none"> • 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 • 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 received the following: <ul style="list-style-type: none"> ○ Client rights and responsibilities ○ Client grievance procedure ○ Information on confidentiality
<p>B. Working collaboratively with the client, the provider conducts a confidential assessment of client's immediate needs.</p>	<p>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.</p> <p>The provider should use an acuity scale as a measurement tool to determine client needs.</p>	<p>Client's File should contain a completed assessment form in the client record covering the following:</p> <ul style="list-style-type: none"> • Medical, mental health, substance use, psychosocial needs, HIV risk behaviors, and basic needs (food, shelter, etc.). <p>A completed acuity level scale in the client's record, including:</p> <ul style="list-style-type: none"> • Client's current level of need

	<p>The acuity scale indicates:</p> <ul style="list-style-type: none"> • The level of case management complexity • The frequency of contact • The complexity of the caseload 	<ul style="list-style-type: none"> • 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 <p>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 (Use) & Mental Illness Symptom Screener (SAMISS) and the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) which is used in the context of SBIRT.</p>
<p>C. Non-medical case management should be responsive to the current situation of the client.</p>	<p>C.1 Reassessment of the client’s needs is conducted as needed, but not less than annually.</p>	<p>Client’s File documents reassessments.</p>
<p>Service Planning</p>		
<p>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.</p>	<p>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:</p> <ul style="list-style-type: none"> • 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. 	<p>All service plans are entered and updated in the data system provided by DHR, or an approved equivalent.</p> <p>Service plan written in a SMART format indicates:</p> <ul style="list-style-type: none"> • Goals • Action steps • Actual outcomes • Changes or updates • Follow up

	<ul style="list-style-type: none"> • 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? 	
<p>E. The provider and the client will work together to create a timeline and decide who will take responsibility for each task.</p>	<p>E.1. A reasonable timeline is determined for achievement of goals, with tasks assigned to either the provider or client.</p>	<p>The service plan indicates the individual responsible for each task:</p> <ul style="list-style-type: none"> • Provider (ex. Case manager) • Client • Family or support • Other staff or agency <p>The service plan indicates anticipated time frame for each task</p>
<p>F. Reassessment of client needs is completed as needed, but not less than every six months.</p>	<p>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.</p>	<p>The Provider will document all updates to the service plan upon achievement of goals, and when other issues or goals are identified, or at least annually when reassessment should occur.</p>
<p>G. Clients should receive non-medical case management that is suited to their situation.</p>	<p>G.1. The service plan should be consistent with needs identified in the comprehensive client assessment.</p>	<p>The service plan should be signed and dated by the provider and client in the client’s file.</p>

<p>H. Non-medical case management should be relevant to the client's current situation.</p>	<p>H.1 The strategy or plan of action should be consistent with the updated service plan including:</p> <ul style="list-style-type: none"> • 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 	<p>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:</p> <ul style="list-style-type: none"> • Progress made towards service plan • Action taken to overcome barriers
<p>Referrals and Care Coordination</p>		
<p>I. The provider will provide referrals, advocacy, and interventions based on the service plan.</p>	<p>I.1 Monitoring involves carrying out of tasks listed in the plan, including the following activities:</p> <ul style="list-style-type: none"> • 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 	<p>Client's File includes ongoing documentation, signed, and dated by the provider, of the following:</p> <ul style="list-style-type: none"> • All client contacts made should include: <ul style="list-style-type: none"> ○ 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 <p>Progress made towards service plan</p>

<p>J. Each client receiving non-medical case management services will receive referrals to those services critical to achieving optimal health and well-being.</p>	<p>J.1 The provider will support the client to initiate referrals that were agreed upon by the client and the provider. Referrals include:</p> <ul style="list-style-type: none"> • 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 	<p>Client’s File documents all of the elements of referral.</p>
<p>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.</p>	<p>K.1. Signed release of information forms are obtained as necessary.</p>	<p>Client’s File contains signed release(s) of information, when necessary.</p>
<p>L. Each client will receive assistance to help problem solve when barriers impede access.</p>	<p>L.1. The provider will work with the client to identify barriers to referrals and assist in finding solutions to address barriers.</p>	<p>Client’s File documents all barriers identified in referral process and the actions taken to resolve them.</p>
<p>M. The provider will ensure clients are accessing needed referrals.</p>	<p>M.1. Provider will utilize a tracking mechanism to monitor completion of all referrals.</p>	<p>Client’s File documents follow-up activities and outcomes.</p>
<p>Transition/Case Closure</p>		
<p>N. At the conclusion non-medical case management services, the client’s goals should have</p>	<p>N.1. Clients should demonstrate one of the non-medical case management case closure criteria.</p>	<p>Client’s File should demonstrate one or more of the following case closure criteria being met:</p> <ul style="list-style-type: none"> • Successful completion of all the goals in the service plan

<p>been met and, when appropriate, there should be a seamless transition to less or more intensive case management services.</p> <p>If the client's needs were not met, or the transition did not occur, the reasons should be appropriate and well-documented.</p>		<ul style="list-style-type: none"> • 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 to locate after multiple attempts, etc.) • Client demonstrates the ability to independently manage their care in a sustainable manner <p>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</p>
<p>O. Provider will complete a transition/case closure summary.</p>	<p>O.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.</p>	<p>Transition/case closure summaries will include:</p> <ul style="list-style-type: none"> • 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
<p>Confidentiality/Documentation</p>		
<p>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>	<p>P.1 A client record progress notes will document the date, the type of encounter, and description of the encounter.</p> <p>Transportation of client records should be handled only by authorized personnel and in a manner to ensure</p>	<p>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.</p>

	security and confidentiality.	
Staff Qualifications		
<p>U. Providers should be appropriately qualified and trained.</p>	<p>U.1. Personnel files should document that providers are appropriately credentialed or demonstrate sufficient mastery of skill and knowledge to deliver the service.</p> <p>Providers will have a one-year period starting on their date of hire to document their qualifications.</p>	<p>Personnel Records should document qualification of providers by the following means:</p> <ul style="list-style-type: none"> • 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). <p>This is in addition to the required trainings outlined in the Universal Service Standards.</p>
<p>X. Meet the client where they are at.</p>	<p>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.</p>	<p>Client’s 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.</p>

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 and must collaborate with the providers of such services:

- **SDAP** 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		
<p>A. Working collaboratively with the client, the provider conducts a confidential assessment of client’s immediate needs.</p>	<p>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:</p> <ul style="list-style-type: none"> • The level of case management complexity 	<p>A completed assessment form in the client’s record covering the following:</p> <ul style="list-style-type: none"> • Medical, mental health, substance use, psychosocial needs, and basic needs (food, shelter, etc.). <p>A completed acuity level scale in the client’s record, including:</p> <ul style="list-style-type: none"> • Client’s current level of need • Evidence that the assessment was completed

	<ul style="list-style-type: none"> • The frequency of contact • The complexity of the provider’s overall caseload <p>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.</p>	<ul style="list-style-type: none"> • Evidence of client is assigned to case management tier based on acuity score. • Evidence acuity level has been updated as needed <p>If client opts out of assessment and/or acuity this is noted in the client’s file.</p> <p>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 (Use) & Mental Illness Symptom Screener (SAMISS) and the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) which is used in the context of SBIRT.</p>
<p>B. Clients should be able to base their health care decisions on accurate, understandable information about their healthcare and support service options.</p>	<p>B.1 Clients should be assessed and counseled regarding resources and programs that might be available to them based on their identified needs.</p> <p>Clients should be assessed for the SDAP Colorado’s State Drug Assistance Program (formerly known as “ADAP”), including both Medication Assistance and Insurance Assistance.</p>	<p>Client’s File should include information related to the client needs assessment and detail the available resources that were provided to the client. include</p>
<p>Referrals and Care Coordination</p>		
<p>C. The provider will develop referral resources to make available the full range of additional services to meet the needs of their clients.</p>	<p>C.1 Provider will develop and maintain comprehensive referral lists for a full range of services.</p>	<p>Referral lists available upon request by DHR.</p>
<p>D. Providers will demonstrate active</p>	<p>D.1. Provider will collaborate with other agencies and providers to</p>	<p>Memoranda of Understanding with services providers on file.</p>

<p>collaboration other agencies to provide referrals to the full spectrum of HIV-related and other needed services.</p>	<p>provide effective, appropriate referrals.</p>	
<p>E. Each client receiving Care Navigation services will receive referrals to those services critical to achieving optimal health and well-being.</p>	<p>E.1. The provider will support the client to initiate referrals that were agreed upon by the client and the provider.</p>	<p>The provider will document when referrals are made as well as attempts to verify follow up of referrals.</p>
<p>Transition/Case Closure</p>		
<p>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 intensive case management services.</p>	<p>F.1 Clients should demonstrate one of the brief contact management case closure criteria.</p>	<p>Client’s File should demonstrate one or more of the following case closure criteria being met:</p> <ul style="list-style-type: none"> • 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 to locate after multiple attempts, etc.) • Client no longer demonstrates the ability to independently manage their care. <p>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.</p>
<p>G. provider will complete a transition/case closure summary.</p>	<p>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.</p>	<p>Transition/case closure summaries will include:</p> <ul style="list-style-type: none"> • Date and sign-off of provider • Date of transition/case closure • Reasons for transition/case closure • Criteria for re-entry into services

Confidentiality/Documentation		
<p>H. Care Navigation records should be complete, accurate, confidential, and secure.</p>	<p>H.1. Client record progress notes will document the date, the type of encounter and description of the encounter.</p> <p>Storage and transportation of client records should be handled only by authorized personnel and in a manner to ensure security and confidentiality.</p>	<p>There is one record per client. Client record entry includes:</p> <ul style="list-style-type: none"> • Date of client visit/contact • Reason for visit/contact • Any activities performed • Outcome plan
Staff Qualifications		
<p>I. Providers staff should be appropriately qualified and trained.</p>	<p>I.1. Personnel files should document that Providers staff are appropriately credentialed or demonstrate sufficient mastery of skill and knowledge to deliver the service.</p> <p>Providers staff will have a one-year period starting on their date of hire to document their qualifications.</p>	<p>Personnel Records should document qualification of the provider by the following means:</p> <ul style="list-style-type: none"> • 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). <p>This is in addition to the required trainings outlined in the Universal Service Standards.</p>
<p>X. Meet the client where they are at.</p>	<p>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.</p>	<p>Client’s 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.</p>

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		
<p>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.</p>	<p>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.</p> <p>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).</p>	<p>A completed assessment form in the client’s record covering the following:</p> <ul style="list-style-type: none"> • Medical, mental health, substance use, psychosocial needs, and basic needs (food, shelter, etc.). <p>A completed acuity level scale in the client’s record, including:</p> <ul style="list-style-type: none"> • Client’s current level of need

	<p>The acuity scale indicates: The level of case management complexity</p> <ul style="list-style-type: none"> • The frequency of contact • The complexity of the provider’s overall caseload <p>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.</p>	<ul style="list-style-type: none"> • 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 <p>If client opts out of assessment and/or acuity this is noted in the client’s file.</p> <p>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 (Use) & Mental Illness Symptom Screener (SAMISS) and the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) which is used in the context of SBIRT.</p>
<p>B. Providers should gather sufficient information from or about the client in order to inform the referral process.</p>	<p>B.1. Information collected should include a minimum of:</p> <ul style="list-style-type: none"> • Name • DOB • Phone Number • Other Contact Information • Type of Referral Requested • Reasons for Request 	<p>Referrals are documented in the client file.</p>
<p>Referrals and Care Coordination</p>		
<p>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.</p>	<p>C.1. The referral service will cover:</p> <ul style="list-style-type: none"> • 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.) 	<p>Client’s File documents all of the elements of referral.</p>

	<ul style="list-style-type: none"> • 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 	
<p>D. Provider has a referral policy that explains how referrals to other providers are made and tracked.</p>	<p>D.1. Provider will detail referral procedures and tracking processes.</p>	<p>Provider has a referral policy on file.</p>
<p>E. Provider will track all referrals made and will document follow-up plan with client and follow-up on referral if agreed upon.</p>	<p>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.</p> <p>All referrals will be tracked by provider, and follow-up/completion is documented when applicable.</p>	<p>Client’s File shows follow-up plan, and documents follow-up efforts.</p>
<p>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 resource document to make available the full range of additional services to meet the needs of their clients.</p>	<p>F.1. Provider will develop and maintain comprehensive referral lists for a full range of services. Including but not limited to:</p> <ul style="list-style-type: none"> • Medical providers; • Oral Health providers; • Substance Use and Mental Health support programs; • Case Management providers; • Housing Services; • Services supporting those experiencing Homelessness; • Legal Services; • Sexual Health Clinics; • Homeless shelters; 	<p>Referral lists and resources available upon request.</p>

	<ul style="list-style-type: none"> • 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’s File 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’s File has release of information on file when necessary (electronic signatures allowable).
Staff Qualifications		
K. Referral Services staff should be appropriately qualified and trained.	<p>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.</p> <p>Referral Services staff will have a one-year period starting on their date of hire to document their qualifications.</p>	<p>Personnel Records should document qualification of providers by the following means:</p> <ul style="list-style-type: none"> • 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

		<p>below; and</p> <ul style="list-style-type: none"> • Completion of the MCM Certificate Online Training (available through DHR). <p>This is in addition to the required trainings outlined in the Universal Service Standards.</p>
<p>X. Meet the client where they are at.</p>	<p>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.</p>	<p>Client’s 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.</p>

Childcare Services

The Ryan White HIV Program (RWHAP) supports intermittent child-care services for the children living in the household of people living with HIV who are RWHAP-eligible clients. The assistance provides short-term, or emergency childcare that enables a client to attend medical visits, related appointments, and/or RWHAP-related meetings, groups, or training sessions.

Allowable uses of funds include, but not limited to:

- A licensed or registered childcare provider to deliver intermittent care
- Informal childcare provided by a neighbor, family member, or other person (federal restrictions prohibit giving cash to clients or caregivers to pay for these services)

Units of Service

1 unit = 30 minutes

Service Components

STANDARD	MEASURE	DATA SOURCE
<p>A. Childcare Services are provided to clients who do not have childcare support available to them and is provided to allow the client to connect to HIV-related health and support services.</p>	<p>A. 1. Childcare services will be delivered to clients with barriers to access HIV-related health and support services.</p>	<p>Client's File documents barriers and how childcare funds are used to access HIV-related health and support services.</p>
	<p>A.2. Providers will document:</p> <ul style="list-style-type: none"> • Date(s); • Duration; • Reason for the assistance (i.e., attending a medical visit); • Actual cost of service. 	<p>Client's File documents reasons, dates, and cost of services.</p>

Early Intervention Services

An Early Intervention Services (EIS) program is a package of services designed to identify and link individuals living with HIV to Outpatient/Ambulatory Health Services (OAHS), Case Management Continuum (CMC), and Behavioral Health Services (Mental Health/Substance Use/Psychosocial), 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, as well as providing health education and literacy. Once a client has been successfully linked to OAHS, the EIS engagement is complete. If a client needs ongoing support, the support will happen in CMC Services.

Early Intervention Services (EIS) for Part A may include:

- HIV testing to help those unaware learn of their HIV status, 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 points of entry;
- Access and linkage to HIV care and treatment services such as OAHS, CMC, MH and SAO/SU; and
- Outreach Services and Health Education/Risk Reduction related to HIV diagnosis.

If an EIS program provides focused 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, active referral(s) to medical case management, behavioral health, or other supportive services was made

Active referral process 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).

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

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
DHR	Denver HIV Resources
DHRPC	Denver HIV Resources 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
SDAP	State Drug Assistance Program (formerly known as “ADAP”)

Units of Service

1 unit = 15 min or less

Service Components

STANDARD	MEASURE	DATA SOURCE
<p>A. Programs funded for EIS Linkage services may provide focused HIV testing services to vulnerable populations.</p>	<p>A.1. Programs providing HIV testing services must create a focused testing plan.</p>	<p>Program’s Policies and Procedures will contain an approved focused HIV testing plan.</p>
	<p>A. 2. Protocols are in place documenting the connection between testing and linkage services, including clear roles, responsibilities, and processes.</p>	<p>Program’s Policies and Procedures will contain the protocol detailing the connection between testing and linkage services, including clear roles, responsibilities, and processes.</p>
	<p>A.3. Testing services must coordinate with other HIV prevention and testing programs to avoid duplication of effort.</p>	<p>Program’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.</p>
	<p>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.</p>	<p>Program’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.</p>
<p>B. EIS Services will be utilized to link individuals who are</p>	<p>B.1. Clients eligible for EIS are individuals identified as not being</p>	<p>Client’s File contains the date of a client’s HIV diagnosis.</p>

<p>identified as not being connected to services needed to maintain their HIV care.</p>	<p>connected to services needed for them to maintain their HIV care.</p>	
	<p>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.</p>	<p>Client's File documents the dates of service and reflects 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.</p>
	<p>B.3. If at any time during this process, a Linkage Referral is made to another EIS Linkage Provider (for example: a referral for confirmatory testing), the responsibility for linking the client to an HIV medical provider, and/or CMC 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.</p>	<p>Client's File will contain the Linkage Referral and documentation confirming the client connected to the new EIS Provider.</p>
<p>C. Clients receiving EIS services will be assessed to identify needs and potential barriers to services. The provider will then develop a Linkage Plan.</p>	<p>C.1. Within three days of referral to EIS services, the client will be contacted to schedule or complete EIS assessment.</p>	<p>Client's File will contain documentation regarding contact with the client, documentation that the client was scheduled to be screened within three business days of a new diagnosis, and an identified need for EIS.</p>
	<p>C.2. Provider will conduct an assessment of needs and barriers linking to medical care and Case Management Continuum as indicated.</p> <p>It may include:</p> <ul style="list-style-type: none"> • Barriers to medical care; • Client's behavioral health; • Substance use; 	<p>Client's File contains an EIS assessment of needs that includes the date of diagnosis, date of the assessment, and the identified priority need areas.</p>

	<ul style="list-style-type: none"> • Financial situation; • Housing situation; • Transportation needs; • Payer source for medical care; and • Health education, risk reduction, and health literacy needs. 	
<p>D. EIS program will link client to an HIV medical provider within 30 days and not to exceed 90 days of entry into EIS.</p>	<p>D.1. Clients will be referred to an HIV medical provider. A release of information will be established between the EIS program and the medical provider.</p>	<p>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.</p>
	<p>D.2. EIS program will confirm client has linked to an HIV medical provider within 30 days and not to exceed 90 days of entry into EIS.</p> <p>If a client has not been linked by day 90, the provider will continue to conduct outreach and engagement efforts until client has been linked.</p>	<p>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.</p> <p>If a client has not been linked by day 90, documentation will reflect, at a minimum, one attempt every two weeks, until the client is linked or they have opted out of EIS services.</p>
<p>E. EIS providers will make a linkage referral to a Case Management Continuum program within 30 days of entry if CMC services are needed and if the client agrees.</p>	<p>E.1. If the EIS screening indicates CMC services are needed and the client agrees, a linkage referral will be made to an CMC program. If the client does not agree, they will be offered information about available CMC programs.</p>	<p>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.</p>
	<p>E.2. Linkage referrals to CMC services will occur within 30 days of</p>	<p>Client’s File documents the date of linkage referral reflecting that it was within</p>

	<p>entering EIS if CMC needs have been identified and/or requested.</p> <p>Program will continue to support the client as needed until they have attended the first CMC appointment.</p>	<p>30 days of entry into EIS and additional support is documented.</p>
	<p>E.3. A release of information will be established between the EIS provider and the CMC program.</p>	<p>Client’s File documents the date of the linkage referral release of information between the EIS program and the CMC program.</p>
<p>F. All EIS clients must have a Linkage Plan.</p>	<p>F.1. The Linkage Plan will document a plan to address the needs identified in the EIS screening. The plan will summarize the needs, action steps, and any noted outcomes.</p>	<p>Client’s File contains a Linkage Plan.</p>
	<p>F. 2. The Linkage Plan will be created at the time of screening, or within one week of the EIS screening.</p>	<p>Client’s File contains a Linkage Plan that identifies the date of when the plan was created.</p>
	<p>F. 3. The linkage plan will document when EIS services have been completed.</p>	<p>Client’s File contains a Linkage Plan that identifies the date when the plan was completed.</p>
	<p>F. 4. If at the end of 90 days, there continue to be barriers to accessing care, the Linkage Plan will be updated or a new plan completed.</p>	<p>Client’s File contains a new Linkage Plan that identifies the barriers and actions to alleviate those barriers with a timeline for service completion.</p>
<p>G. Progress notes will be completed after every contact with the client.</p>	<p>G.1. Progress notes demonstrate that the Linkage Plan is being implemented and followed or revised to meet the client’s needs.</p>	<p>Client’s File contains progress notes.</p>

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

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
PLHIV	Person(s) Living With HIV
RWHAP	Ryan White HIV/AIDS Program
SDAP	State Drug Assistance Program (formerly known as “ADAP”)

Units of Service

1 unit = any assistance request (including denied requests)

Service Components

STANDARD	MEASURE	DATA SOURCE
<p>A. Client eligibility is based on income level.</p> <p>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.</p>	<p>A.1. Payments may be made for the following services (but is not limited to the listed services below), and may include past due charges, but do not include items in collections:</p> <ul style="list-style-type: none"> - Phone & Internet: Payment for cable is not allowable. - Water - Trash - Utilities: Payments may be made for electric, gas, and sewer. 	<p>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.</p>

<p>EFA funds may not be used for clothing, or direct cash payments</p>	<ul style="list-style-type: none"> - HIV-related medication not covered by SDAP (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 SDAP. Utilization of SDAP must be ruled out first. Includes past due charges, however charges may not be in collections. Payments cannot be made to a current Ryan White Part A Program. - Optical: Payments may be made for copayments, prescription eye wear, but not the exam. 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 childcare through a licensed childcare 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. 	
	<p>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.</p>	<p>Client’s File contains complete and signed medical waiver, if applicable.</p>

	<p>To be approved for a medical waiver an individual must:</p> <ul style="list-style-type: none"> • 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. 	
<p>B. Programs will have procedures for clients to gain EFA assistance, deny EFA requests, and handle inappropriate use of funds. Eligibility criteria will be applied equally to all clients regardless of program.</p>	<p>B.1. The client and program will meet in a way that allows client participation (i.e., in person, virtually, by email, or by phone) to process the housing request.</p>	<p>Client’s File contains documentation of client participation in the process.</p>
	<p>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.</p>	<p>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.</p> <p>Program’s Policies and Procedures demonstrates a process for notifying the client and the single payer of the suspension.</p>
<p>C. Single payer will respond to check requests in a timely manner and maintain payment records.</p>	<p>C.1. Checks for EFA will be issued by the contracted single payer program.</p>	<p>Single payer records contain check information.</p>
	<p>C.2. Checks will be sent to the vendor address listed on the request. Checks cannot be payable or issued to clients.</p>	<p>Single payer records demonstrate that checks will be sent to the vendor.</p>

	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 3 – 5 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 them 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
<p>A. Staff and volunteers have appropriate skills, relevant training, and knowledge about HIV and safe food handling.</p>	<p>A.1. Staff or volunteers involved in food preparation and/or food distribution will complete a <u>food safety class</u> equivalent to State of Colorado standards.</p>	<p>Personnel files document staff and volunteer training hours.</p>
	<p>A.2. Supervisory staff will stay current with the latest information on HIV and nutrition by attending trainings on an annual basis.</p>	<p>Personnel file will document topic specific training.</p>
<p>B. Funding for Food Bank/Home-delivered Meals will cover HRSA-approved food items and essential non-food items.</p>	<p>B.1. Allowable costs include:</p> <p>Food items:</p> <ul style="list-style-type: none"> • The provision of actual food items; • Provision of frozen, cold, or hot meals; and • A voucher program to purchase food. <p>Essential non-food items:</p> <ul style="list-style-type: none"> • Personal hygiene products; • Household cleaning supplies; and • Water filtration/ purification systems in communities where issues with water purity exist. 	<p>Program’s Policies and Procedures will document allowable costs under RWHAP.</p>
	<p>B.2. Unallowable costs include:</p> <ul style="list-style-type: none"> • Household appliances; • Pet foods; • Permanent water filtration systems for water entering the house; and • Other non-essential products. 	<p>Provider’s policies and procedures will document un-allowable costs under RWHAP.</p>
	<p>B.3. Documentation that:</p> <ul style="list-style-type: none"> • Services supported are limited to food bank, home- delivered meals, and/or food voucher program; • Types of non-food items provided are allowable; and 	<p>Program’s Policies and Procedures document allowable and unallowable costs under RWHAP.</p>

	<ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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
E. Food banks will make sure their services are accessible for clients.	E.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.
	E.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
<p>F. Home delivered meals will be provided in a manner convenient to the client and will meet the client’s nutritional needs.</p>	<p>F.1. Participants will be given a delivery time period within which they can expect to receive their meals.</p>	<p>Provider’s policies and procedures address communication and standards around delivery of food.</p>
	<p>F.2. Meals will have caloric and nutritional content to meet the individual participant’s dietary needs.</p>	<p>Program’s Menus demonstrate each meal’s average caloric and nutritional content.</p>
	<p>F.3. Menus will be made in conjunction with RD to ensure it meets the participants’ nutritional needs.</p>	<p>Program’s Policies and Procedures contain documentation that registered dietitian signed off on the menu.</p>
<p>G. 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.</p>	<p>G.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.</p>	<p>Program’s Policies and Procedures contain documentation that program is following accepted nutrition standards.</p>
<p>H. Program must assess needs of each client receiving home-delivered meals at least once a year to assure compliance with service requirements.</p>	<p>H.1 Provider assesses client needs and status at least once a year and includes:</p> <ul style="list-style-type: none"> • Dietary and cultural food needs; • Food preferences; and • Client’s ability to access services. 	<p>Client’s File show annual assessment of need.</p>

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
PLHIV	People Living With HIV

Units of Service

1 unit = any assistance request (including denied requests)

Service Components

STANDARD	MEASURE	DATA SOURCE
<p>A. Client eligibility is based on income level.</p> <p>Clients between 0-500 percent of FPL are eligible for housing assistance not to exceed \$1,200 for the current fiscal year.</p> <p>Housing services funds may not be used for rental deposits or mortgage payments.</p> <p>Clients who receive a housing subsidy are eligible for housing assistance not to exceed \$600 for the current fiscal year.</p>	<p>A.1. Payments may be made for the following services, and may include past due charges, but do not include items in collections:</p> <p>Rental Assistance: Payments may be made for rent assistance.</p> <p>Hotel/Motel: Payments may be made for a hotel, or motel.</p>	<p>Client’s File contains documentation including a lease, letter, or other proof of dollars needed and vendor to be paid.</p> <p>If it is a sublease, the vendor must be the property owner.</p> <p>A family member may be the vendor if they are the property owner.</p> <p>If property owner is an individual, not a company, owner must be verified using the County assessor’s website(s).</p> <p>For clients who receive a housing subsidy, documentation of the housing subsidy should be included when requesting housing assistance.</p>

	<p>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.</p> <p>To be approved for a medical waiver an individual must:</p> <ul style="list-style-type: none"> • 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. 	<p>Client’s File contains complete and signed medical waiver, if applicable.</p>
<p>B. Programs will have procedures for clients to gain housing assistance, deny housing requests, and handle inappropriate use of funds. Eligibility criteria will be applied equally to all clients regardless of program.</p>	<p>B.1. The client and program will meet in a way that allows client participation (i.e., in person, virtually, by email, or by phone) to process the housing request.</p>	<p>Client’s File contains documentation of client participation in the process.</p>
	<p>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.</p>	<p>Client’s File contains a copy of the financial plan or a program specific planning tool.</p>
	<p>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</p>	<p>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</p>

	client will be made aware of how to appeal the suspension.	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.

Linguistic Services

Linguistic Services include interpretation and translation activities, including oral, visual, and written services to eligible clients. These activities must be provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare provider and the client. These services are to be provided when such services are necessary to facilitate communication between the provider and client and/or support delivery of HRSA RWHAP-eligible services. Linguistic Services must comply with the [National Standards for Culturally and Linguistically Appropriate Services \(CLAS\)](#).

Definitions and Descriptions

Translation services are written services provided by a qualified individual as a component of HIV service delivery between the provider and the client.

Interpretation services are oral and visual services provided by a qualified individual as a component of HIV service delivery between the provider and the client.

Acronyms

AACI	American Consortium of Certified Interpreters
AIDS	Acquired Immunodeficiency Syndrome

DHR	Denver HIV Resources
HIV	Human Immunodeficiency Virus
PLHIV	People Living With HIV
LEP	Limited English Proficiency

Units of Service

Service units of linguistic services are defined as the number of minutes of provided interpretation and/or translation provided on behalf of the client.

1 Unit = 30 minutes or less

Service Components

STANDARD	MEASURE	DATA SOURCE
<p>A. The program will provide linguistic services when interpretation and/or translation is necessary to facilitate communication between the provider and client, as well as support delivery of RWHAP-eligible services.</p>	<p>A.1. Linguistic services will be provided as a component of HIV service delivery between the healthcare provider and the client.</p>	<p>Program’s Policies and Procedures show linguistic services as a component of service delivery</p>
	<p>A.2. Linguistic services will comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) (link here).</p>	<p>Program’s Policies and Procedures show compliance with CLAS</p>
<p>B. Linguistic services are provided by appropriately trained and qualified individuals holding the appropriate State or local certification.</p>	<p>B.1. Individuals providing interpretation and/or translation services will have completed a medical interpreter training that includes, but is not limited to:</p> <ul style="list-style-type: none"> • Proficient interpreting skills; • Code of ethics; • Knowledge of the healthcare system (and HIV care preferred); • Basic medical terminology; • Culture and its impact on medical interpretation; and • Communication skills for advocacy. 	<p>Personnel file demonstrates the type, amount (minutes or hours), and date of training that each staff receives both internally and externally.</p>
<p>C. Linguistic services include in-person, over-the phone, and video interpretation services as well as written</p>	<p>C.1. Programs ensure access to in one or a combination of the following ways for clients with Limited English Proficiency</p>	<p>Program’s Policies and Procedures demonstrate that interpretation services are provided in various</p>

<p>translation services. Services will be provided in a manner that has the greatest likelihood of ensuring maximum participation in the program involved.</p>	<p>(listed in order of preference):</p> <ul style="list-style-type: none"> • Bilingual staff or who can communicate directly with clients in preferred language; • Interpretation provided by: <ul style="list-style-type: none"> ○ Qualified staff, contract interpreters, or volunteer interpreters in-person; ○ Phone service interpretation; or ○ Video interpretation services. • Written translation; or • Referral to programs with bilingual clinical administrative and support staff and/or interpretation services by a qualified bilingual/bicultural interpreter 	<p>ways to meet the clients' needs.</p>
	<p>C.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.</p>	<p>Client's File contains signed consent form that requests family member or friend to provide interpretation services.</p>

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

Acronyms

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

Units of Service

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

Service Components

STANDARD	MEASURE	DATA SOURCE
A. Transportation allows clients to connect to HIV-related health and support services who do not have the means to access them on their own or need vehicle mileage reimbursement assistance.	A.1. Transportation funds will be used in a manner that is most cost effective and appropriate for the client.	Program’s Policies and Procedures demonstrate how transportation funds are delivered and how they ensure cost effectiveness.
	A.2. Transportation services will be delivered to clients with transportation barriers to access HIV-related health and support services.	Client’s File documents barriers and how transportation funds are used to access HIV-related health and support services.
	A.3. Distribution of transportation service must document: <ul style="list-style-type: none"> • Client name or other identifier • Type of distribution: <ul style="list-style-type: none"> • cab voucher; • mileage reimbursement; • bus ticket; or • rideshare trip. • Units distributed • Date 	Client’s File documents the distribution of the transportation service.

	<ul style="list-style-type: none"> • Purpose • Type of distribution: <ul style="list-style-type: none"> ○ <u>Bus ticket</u> ○ <u>Cab voucher</u>: must include origin and destination ○ <u>Mileage reimbursement</u>: 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 ○ <u>Rideshare</u>: must include 1) trip origin and destination, and 2) a receipt from rideshare trip that is signed by service provider. 	
<p>B. The program will provide mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical and other support services.</p>	<p>B.1. The program has a system for providing mileage reimbursement (through a non-cash system) that does not exceed the <u>federal per-mile reimbursement rate</u> for the current calendar year.</p>	<p>Program’s Policies and Procedures document that vehicle mileage is reimbursed <i>after the trip</i> at the federal per-mile reimbursement rate.</p>
<p>C. The program utilizes RTD discount purchase programs when possible.</p>	<p>C.1. Transportation services will be purchased at a discount rate from RTD when possible.</p>	<p>Program’s Policies and Procedures show that transportation services are purchased at a discounted rate when possible.</p>
<p>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.</p>	<p>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.</p>	<p>Program’s Policies and Procedures detail which rideshare services the program partners with, and evidence of HIPAA compliance.</p>
	<p>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</p>	<p>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.</p>

	rideshare trip can only cover the established rate for federal programs and may not cover the full amount the client paid for the trip.	
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Mental Health Services

Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. They are conducted in a group or individual setting, and provided by a licensed mental health professional or authorized professional within the state to render such services. Such professionals typically include psychiatrists, psychologists, licensed professional counselors, nurse practitioners, and licensed clinical social workers.

In some cases, a client may be seen for psychotherapy services, psychiatric needs, or for a brief intervention in an integrated care setting. The standards that apply to all services provided under this category are listed first under “All Mental Health Services Components”. The standards that apply to only ongoing psychotherapy services are listed under “Psychotherapy Services Components,” and the standards that apply only to brief interventions are listed under “Integrated MH Service Components.” Psychiatric services are covered in the “Psychiatric Services Components” section.

Definitions and Descriptions

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 = 15 min or less

I. All Mental Health Services Components

STANDARD	MEASURE	DATA SOURCE
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<p>A. Providers of mental health services must have the proper qualification and expertise to deliver services.</p>	<p>A.1. Mental health services can be provided by a:</p> <ul style="list-style-type: none"> · Psychiatrist; · Licensed Psychologist; · Licensed Psychiatric Nurse Practitioner; · Licensed Marriage and Family Therapist; · Licensed Professional Counselor; · Licensed Clinical Social Worker; · Or other licensed/authorized providers. 	<p>Personnel File has proof of certification/ Licensure for the position.</p>
	<p>A.2. Mental health services can be provided by registered psychotherapist, masters level candidate status provider or graduate level student interns with appropriate supervision per licensure or internship regulations and in compliance with Colorado Mental Health statutes (link here).</p>	<p>Personnel File clearly designates a supervisor.</p>
<p>B. Treatment will be offered in a timely manner.</p>	<p>B.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.</p>	<p>Client's File contains a dated referral, and evidence of the date of first treatment.</p>
<p>C. Referrals made to services related to the treatment plan shall be made and documented in a timely manner.</p>	<p>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.</p>	<p>Client's File will contain documentation of referrals.</p>

<p>D. Progress notes shall be completed after every contact with the client.</p>	<p>D.1. Progress notes should:</p> <ul style="list-style-type: none"> · Be a written chronological record; · Assess and document any change in physical, behavioral, cognitive, and functional condition; · Document any action taken by staff to address the client’s changing needs; and · Be signed and dated by the author at the time they are written, with at least a first initial, last name, degree and/or professional credentials. 	<p>Client’s File contains copies of progress notes.</p>
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II. Psychotherapy Services Components

STANDARD	MEASURE	DATA SOURCE
<p>E. Providers of mental health services will utilize a mandatory disclosure form in compliance with Colorado mental health statutes.</p>	<p>E.1. Therapeutic disclosure will be reviewed and signed by all clients and must be compliant with Colorado Mental Health statutes (link here). At a minimum, the disclosure must include:</p> <ul style="list-style-type: none"> · 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; 	<p>Client’s File contains a copy of the therapeutic disclosure, signed, and dated by both client and therapist.</p>

	<ul style="list-style-type: none"> · 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. 	
<p>F. A biopsychosocial assessment will begin at the first session and be completed by the second session.</p>	<p>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:</p> <ul style="list-style-type: none"> · Presenting problem; · Mental Status Exam (MSE) - physical, behavioral, cognitive, and functional condition; · Medical and psychiatric history; · Family history; · Treatment history; · Cultural issues; · Spiritual issues when pertinent; · Brief psychosocial history; · Diagnosed mental health illness or condition; 	<p>Client's File contains a copy of the biopsychosocial assessment.</p>

<p>G. Every client shall have a treatment plan which guides their care.</p>	<p>G.1. All treatment plans will be discussed and created in collaboration with the client and reflects the client's individual needs and preferences. Treatment plans will:</p> <ul style="list-style-type: none"> · Be based on the biopsychosocial assessment indicating the client's specific needs and preferences; · Contains client driven goals which define what the client expects to achieve during treatment; · Be completed by the fourth session and updated every six months. 	<p>Client's File contains a copy of the treatment plan.</p>
<p>H. Upon closure of active mental health services, a client case is closed and contains a closure summary documenting the case disposition.</p>	<p>H.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:</p> <ul style="list-style-type: none"> · 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; · Documentation of referrals and recommendations for follow-up care 	<p>Client's File contains a copy of closure summary if patient's case has been closed.</p>

<p>I. The provider will regularly review with clients access/barriers to medical appointments and medications.</p>	<p>I.1. The provider will document the discussion with the client about access/barriers to medical appointments and medications. Discussions may include:</p> <ul style="list-style-type: none"> • Assessing for barriers; • Impact on mental and emotional health; • Need for support; • Identifying additional areas where collaboration and/or coordination may be needed. 	<p>Client’s File contains documentation of the discussion with the client and/or any coordination of care as clinically indicated.</p>
<p>J. The program must use evidence-based practices or care supported by empirical evidence.</p>	<p>J.1. The program uses evidence-based practices, including but not limited to:</p> <ul style="list-style-type: none"> • Motivational Interviewing; • Harm Reduction; • Cognitive Behavioral Therapy; • Dialectical Behavior Therapy; • Trauma-Informed Treatment; and • Psychoeducation. 	<p>Program’s Policies and Procedures documents which practices are implemented. This may include a formal policy and/or inclusion in the provider disclosure.</p>

III. Integrated MH Services (Brief Intervention) Components

STANDARD	MEASURE	DATA SOURCE
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<p>K. Integrated Brief Intervention Services will be provided as a part of a larger, integrated, medical visit with the client.</p>	<p>K.1. Clients will be offered the opportunity to engage with brief intervention services while at a clinic visit and/or are provided brief services upon request.</p>	<p>Program’s Policies and Procedures document how in an integrated behavioral health care program, brief intervention services are being implemented and how clients can access services.</p>
<p>L. A brief, informal, clinical assessment of the client’s presenting needs will be conducted to determine that the client’s needs are appropriate for engagement in brief intervention services (limited to 1-2 consecutive, integrated clinical encounters) and would not be better supported by referral and engagement in ongoing mental health treatment.</p>	<p>L.1. An informal assessment of the client’s presenting needs will be done at each integrated visit and will document how the client’s needs are appropriate for engagement in a brief intervention service.</p>	<p>Client’s File contains documentation that the client’s needs were assessed and the indication for a brief intervention was documented and is in the encounter note for the visit.</p>
	<p>L.2 All client assessments will include a safety assessment and plan.</p>	<p>Client’s File contains a copy of the safety assessment and plan. The safety assessment and plan is documented in an encounter (or visit) note or other EMR record.</p>

	<p>L.3 There should be a documented plan (encounter note) outlining next steps and it will:</p> <ul style="list-style-type: none"> · Be based on the presenting needs of the client. · Contain the identified next steps 	<p>Client's File contains a copy of the plan. The plan is documented in an encounter (or visit) note or other EMR record.</p>
	<p>L.4. The program will refer to other services for ongoing mental health or psychiatric care as needed and will document all referrals to internal or external care and services.</p>	<p>Client's File contains documentation of referrals. Referrals may be documented in an encounter (or visit) note or other EMR record.</p>

IV. Psychiatric Services Components

Psychiatric treatment services are conducted in an individual setting and provided by a psychiatrist, psychiatric nurse practitioner, or another clinician authorized within the State of Colorado to render such services and may include the prescription of medication and/or referrals to other types of mental health services.

STANDARD	MEASURE	DATA SOURCE
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<p>M. A psychiatric assessment will be completed for all patients.</p>	<p>M.1 The psychiatric assessment is completed at the first visit and that it reflects the client's immediate clinical needs.</p>	<p>Client's File contains results from psychiatric assessment, with evidence that charting was completed within 48 hours of visit.</p>
<p>N. Every client shall have a treatment plan which guides their care.</p>	<p>N.1 All treatment plans will be discussed and created in collaboration with the client and will reflect the client's individual needs and preferences.</p> <p>Treatment plans will:</p> <ul style="list-style-type: none"> · Be based on the psychiatric assessment and should indicate the client's needs and preferences; · Plans should be reviewed and revised as needed, depending on the scope of the services being provided. · 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. 	<p>Client's File documentation of the treatment plan.</p>
<p>O. The program will refer to other services for ongoing mental health or other behavioral health service as needed.</p>	<p>O.1. Referrals to qualified practitioners and/or services will occur if clinically indicated. All internal and/or external referrals will be documented in the client's file.</p>	<p>Client's File will contain documentation of referrals.</p>

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 PLHIV. 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
SDAP	State Drug Assistance Program (formerly known as “ADAP”)

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	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

<p>proper qualifications and expertise to deliver services.</p>	<p>A.2. If a program utilizes the services of dental students, these students must be supervised according to their program guidelines and work under the license of a program's dentist.</p>	<p>passed by the State Board will be in the Dentist's file.</p> <p>Program's Policies and Procedures demonstrate how students are supervised to ensure high levels of quality.</p>
<p>B. Treatment will be offered in a timely and appropriate manner.</p>	<p>B.1. Program can demonstrate that waiting list procedure properly manages the wait time for new clients.</p>	<p>Program's Policies and Procedures demonstrate how the program handles waiting lists.</p> <p>Client's File shows that there are no unnecessary delays in getting services.</p>
	<p>B.2. Program determined emergencies will be addressed or referred to another provider within 24 hours.</p>	<p>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.</p> <p>Program's Policies and Procedures outline how emergencies are handled in a timely manner.</p>
<p>C. A comprehensive oral evaluation will be given to people with HIV presenting for dental services.</p>	<p>C.1. The evaluation will include:</p> <ul style="list-style-type: none"> • 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; 	<p>Client's File will have a signed and dated oral evaluation on file in patient chart.</p>

	<ul style="list-style-type: none"> • Complete intra-oral exam, including evaluation for HIV associated lesions; • Pain assessment; • Dental and Medical History; • Psychological and behavioral health histories; • Dental Treatment Plan; and • Oral Health Education. 	
	<p>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.</p>	<p>Client’s File contains a medical needs evaluation and a referral to primary care if necessary.</p>
	<p>C.3. Provider clinical decisions are supported by the American Dental Association Dental Practice Parameters.</p>	<p>Program’s Policies and Procedures reference the American Dental Association Dental Practice Parameters.</p>
<p>D. A comprehensive treatment plan is developed based upon the initial examination of the client.</p>	<p>D.1. Completed treatment plan in client file at the subrecipient location, submitted by dentist.</p>	<p>Client’s File contains a treatment plan.</p>
	<p>D.2. For non-emergent care, the treatment plan should be completed after the evaluation and before the first treatment.</p>	<p>Client’s File contains treatment plan that is completed and documents the medical necessity of restorative care.</p>
<p>E. Treatment plan is reviewed and updated as deemed necessary by the dental provider.</p>	<p>E.1. Updated treatment plan in client file at the subrecipient location, submitted by dentist, and revised and approved by dental program director.</p>	<p>Client’s File contains an updated treatment plan.</p>
<p>F. Progress notes shall be completed after every contact with the client.</p>	<p>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,</p>	<p>Client’s File contains progress notes related to treatment plan.</p>

	<p>excluding external factors outside of the dental provider’s control (e.g., client missing appointments).</p>	
	<p>F.2. Progress notes demonstrate that the client received oral health education at least once in the measurement year.</p>	<p>Client’s File contains progress notes showing client received oral health education.</p>
<p>G. Providers will follow ethical and legal requirements.</p>	<p>G.1. Providers will act in accordance to Colorado State law and the American Dental Association’s Principles of Ethics and Code of Professional Conduct, and respective agencies code of ethics.</p>	<p>Client’s File demonstrates the provider is acting ethically and in the best interest of the client.</p>
<p>H. Closure shall be documented, and proper referrals made if applicable.</p>	<p>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)</p>	<p>Client’s File states reason for closure and that proper referrals are made.</p>
	<p>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.</p>	<p>Client’s File shows proper treatment is given based on the dentist’s professional opinion.</p>
<p>I. Programs shall strive to retain patients in oral health treatment services.</p>	<p>I.1. Programs shall develop a missed appointment policy to ensure continuity of service and retention of clients.</p>	<p>Program’s Policies and Procedures contain a written policy for missed appointments.</p>
	<p>I.2. Programs shall provide regular follow-up procedures to encourage and help maintain a client in oral health treatment services.</p>	<p>Client’s File contains documentation of attempts to contact in signed, dated progress notes. Follow-up may include:</p> <ul style="list-style-type: none"> • Telephone calls;

		<ul style="list-style-type: none"> • Written correspondence; or • Direct contact.
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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
J. Program will assess client eligibility for dental assistance.	J.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.
	J.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.
K. Dental assistance payments can be made for client out-of-pocket costs for oral health care services.	K.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.
	K.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.
<p>L. Program will assist the client with accessing and receiving dental assistance, including scheduling, and coordinating dental appointments.</p>	<p>L.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.</p>	<p>Client’s File contains documentation of client participation in the process.</p>
	<p>L.2. The program will schedule and coordinate all initial dental appointments and educate the client about scheduling any follow up appointments.</p>	<p>Client’s File includes documentation of scheduled appointments.</p>
<p>M. Single payer will respond to check requests in a timely manner and maintain payment records.</p>	<p>M.1. Checks for dental assistance will be issued by the contracted single payer program.</p>	<p>Single payer records contain check information.</p>
	<p>M.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.</p>	<p>Single payer records demonstrate that checks are issued directly to the vendor.</p>
	<p>M.3. The single payer will maintain electronic records of checks related to dental assistance requests.</p>	<p>Single payer records contain check information.</p>
	<p>M.4. Approved check request will be completed within three business days of the request date.</p>	<p>Single payer records demonstrate that check requests were completed in a timely manner.</p>
<p>N. Upon approval of a dental assistance request, the single payer will hold the requested dollar amount for 90 days.</p>	<p>N.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.</p>	<p>Single payer records contain documentation of pertinent dental assistance request information.</p>
	<p>N.2. The single payer will inform the requestor of the approval and availability of the requested dollar</p>	<p>Single payer records contain a process for</p>

	amount for 90 days, with the date of expiration explicitly stated.	communicating with the requestor.
	N.3. Requests approved on or after November 30 th will expire on the last day of the fiscal year.	Single payer records contain documentation of dental assistance request expiration dates.
O. 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.	O.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
PLHIV	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
<p>A. The program will ensure that clients have timely access to medical care.</p>	<p>A.1. The program has policies and procedures in place that address identifying new and established patients as having emergent, urgent, and acute needs.</p>	<p>Program’s Policies and Procedures indicate how emergent, urgent, and acute needs are identified.</p>
	<p>A.2. The program has policies and procedures that facilitate timely, appropriate care determined by the level of need of the client.</p>	<p>Program’s Policies and Procedures indicate how emergent, urgent, and acute needs are managed.</p>
	<p>A.3. The program will have availability to see new clients diagnosed with HIV within 30 days of referral or first contact.</p>	<p>Program’s Policies and Procedures detail how new clients are accepted, processed, and scheduled.</p>
<p>B. Clients will have access to information about how to obtain care and health information.</p>	<p>B.1. The program should, at a minimum, inform the client about:</p> <ul style="list-style-type: none"> • How to access emergency services; • How to schedule appointments; and • How to obtain laboratory or other diagnostic screening results. 	<p>Program’s Policies and Procedures demonstrate how they educate patients on access to care and health information.</p>
	<p>B.2. The program will provide health literacy assistance, when necessary.</p>	<p>Program’s Policies and Procedures demonstrate how they assess and address health literacy.</p>
<p>C. If a client is in need of inpatient care, the program must be able to refer or provide the client with inpatient care.</p>	<p>C.1. Outpatient programs that do not provide inpatient care will maintain referral relationships with other programs that provide inpatient care to PLHIV.</p>	<p>Program’s Policies and Procedures demonstrate the process by which clients are referred to inpatient care.</p>

<p>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.</p>	<p>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 (link here)</p>	<p>Client’s File contains a comprehensive HIV-related history, evidence of physical exams, and relevant laboratory results.</p>
	<p>D.2. The program will schedule regular client visits based on provider recommendation and according to the USDHHS guidelines (link here)</p>	<p>Client’s File contains documentation of client visits and provider recommendation for frequency of client follow-up visits.</p>
<p>E. The program will assist the client with management of medication therapy and treatment adherence.</p>	<p>E.1. The program will have access to medication therapy and medication financial assistance programs, and prescribe medication based on the USDHHS guidelines (link here)</p>	<p>Program’s Policies and Procedures outline access to medication therapy and medication financial assistance programs.</p>
	<p>E.2. The program will develop, implement, and monitor strategies to support treatment adherence and retention in care.</p>	<p>Program’s Policies and Procedures outline strategies to support treatment adherence and retention in care.</p>
<p>F. If the client needs specialty care, the program must be able to refer them to a specialty care provider.</p>	<p>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 PLHIV including substance use treatment, oral health, and case management.</p>	<p>Program’s Policies and Procedures contain documentation of the process for making referrals to specialty care providers.</p> <p>Client’s File indicates care coordination with or referral to specialty care provider.</p>
<p>G. The program will systematically assess retention of clients.</p>	<p>G.1. The program will use monitoring and outreach strategies for clients who have not received recommended care.</p>	<p>Program’s Policies and Procedures outline strategies to outreach clients.</p> <p>Client’s File indicates that the program used</p>

		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.

Other Professional Services

People living with HIV may encounter restrictive social, economic, and systemic conditions that can be mitigated through access to legal information, advice, and services. Other Professional Services allow for the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities.

Other professional services are services to individuals with respect to powers of attorney, living wills, do-not-resuscitate orders, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White HIV/AIDS Program. Legal services to arrange for guardianship, joint custody, or adoption of children after the death of their primary caregiver should be reported as a permanency planning service.

Other professional services exclude criminal defense and class-action suits unless related to access to services eligible for funding under the RWHAP. It is expected that all other sources of funding in the community for other professional services will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort.

Acronyms

ABA	American Bar Association
AIDS	Acquired Immunodeficiency Syndrome
CBA	Colorado Bar Association
DHR	Denver HIV Resources
HIV	Human Immunodeficiency Virus
PLHIV	Person(s) Living With HIV
SSDI	Social Security Disability Insurance
SSI	Social Security Income
TGA	Transitional Grant Area

Units of Service

1 unit = 1 visit

Service Components

STANDARD	MEASURE	DATA SOURCE
<p>A. Other professional services attorneys are licensed by the state of Colorado and practice according to professional rules of conduct.</p>	<p>A.1. Attorneys and pro bono attorneys are licensed by the state of Colorado and are members in good standing with the State Bar of Colorado.</p>	<p>Personnel File contains appropriate licensure.</p>
	<p>A.2. Attorneys and pro bono attorneys will practice according to the:</p> <ul style="list-style-type: none"> • American Bar Association's Model Rules for Professional Conduct and • Colorado Bar Association's Rules of Professional Conduct. 	<p>Program's Policies and Procedures demonstrate that attorneys practice according to the rules of conduct.</p>
	<p>A.3. Unlicensed staff are supervised by licensed attorneys.</p>	<p>Program's Policies and Procedures show that unlicensed staff are supervised.</p>
<p>B. Program staff will respond to clients in a timely manner.</p>	<p>B.1. Program staff will respond to clients within three business days.</p>	<p>Program's Policies and Procedures contain a process for responding to clients.</p>
<p>C. Program will have a client intake process.</p>	<p>C.1. Program intake process will include:</p> <ul style="list-style-type: none"> • Assessment of legal needs and medical care status; • Screening for duplication of services; and • Collection of client information. 	<p>Program's Policies and Procedures contain a client intake process.</p>
<p>D. The provision of other professional services is provided to eligible clients for services allowable under the RWHAP Part A.</p>	<p>D.1. Allowable other professional services include:</p> <ul style="list-style-type: none"> • Legal representation, assistance, counselling, advocacy, and education; • Assistance with public benefits such as SSI and SSDI; • Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it 	<p>Program's Policies and Procedures document what services are provided to the client.</p>

	<p>relates to services eligible for funding under the HRSA RWHAP;</p> <ul style="list-style-type: none"> • Preparation of healthcare power of attorney, durable powers of attorney, and living wills; • Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including: <ul style="list-style-type: none"> ○ Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney; and ○ Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption; • Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits; and • Immigration and naturalization. 	
	<p>D.2. RWHAP Part A funds unallowable costs include:</p> <ul style="list-style-type: none"> • traffic violations; • criminal defense; and • class-action lawsuits unless related to access to services eligible for funding under the RWHAP. 	<p>Program’s Policies and Procedures document unallowable other professional services.</p>
<p>E. Program will refer clients to other programs for other professional services that are beyond the scope of the RWHAP funded program.</p>	<p>E.1. If the client’s needs are beyond the scope of the other professional services provided by the RWHAP-funded program, the program will make referrals to services and/or programs based on the requests and preferences of the client.</p>	<p>Program’s Policies and Procedures include a process for referring clients.</p>
	<p>E.2. Program will inform clients of additional RWHAP core and support</p>	<p>Program’s Policies and Procedures include a process for</p>

	services and refer the client to these services if requested.	referring clients to additional RWHAP services.
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Psychosocial Support Services

Psychosocial support services and programs are designed to help clients connect with peers, promote self-advocacy and explore strategies for living self-defined healthy lives.

Psychosocial services are not clinical in nature and differ from mental health and substance use services. It is strongly encouraged that people leading services in this category are people living with HIV.

Services funded under Psychosocial can include:

- Support Groups
- One-on-One support
- Spiritual and Faith Based support services

Support services may include food, transportation, or childcare assistance to support participation in one-on-one and group sessions.

Units of Service

1 unit = 15 min 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. Clients will receive support to: <ul style="list-style-type: none"> • Navigate medical and support services; • Develop and enhance social and communication tools; • Promote and sustain a sense of self-efficacy; • Ability to self-advocate; 	Client’s File contains documentation of the encounter, topics discussed, and strategies used to reduce the client’s sense of social isolation.

	<ul style="list-style-type: none"> • Develop and utilize coping strategies; • Reduce stigma around HIV and disclosure; • Increase social connection with peers; • Meet other Psychosocial need(s). 	
<p>B. Psychosocial support group sessions will have established ground rules to support discussion and a safe environment.</p>	<p>B.1. Facilitator(s) and session participants will develop and use ground rules, which at a minimum cover:</p> <ul style="list-style-type: none"> • Confidentiality; • Aspects of self-care, safety, and inclusivity; • Respectful Communication; • Applicable Mandatory Reporting. <p>B.2. Ground rules are in written form and verbally reviewed at each session.</p>	<p>Program’s File contain a copy of the ground rules with the sessions’ records.</p>
<p>C. Psychosocial support sessions will be open to PLHIV regardless of whether they are current service recipients at the program providing the service.</p>	<p>C.1. Programs will permit attendance for PLHIV not receiving other Ryan White Part A services. 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.</p> <p>C.2. Services may involve affected individuals in need of social support.</p>	<p>Program’s Policies and Procedures demonstrate a process for determining client eligibility for attendees and how service utilization will be documented.</p> <p>Program’s Policies and Procedures demonstrate how service utilization will be documented.</p>
<p>D. Psychosocial support services must be open to all eligible clients regardless of religious affiliation.</p>	<p>D.1. If the program provides spiritual or faith based support services, it must be available to all eligible clients regardless of religious denominational affiliation.</p>	<p>Program’s Policies and Procedures indicates that services are open to all eligible clients regardless of religious affiliation.</p>

<p>E. The program will refer clients to behavioral health services, medical case management, and/or other core and support services, as appropriate and indicated by the client.</p>	<p>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.</p>	<p>Program’s Policies and Procedures documents process of referring clients to the appropriate services.</p>
<p>F. The structure, content and logistics of psychosocial support groups will be based on the clients’ needs and interests identified through ongoing formative evaluation or group discussion.</p>	<p>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 may consider the following:</p> <ul style="list-style-type: none"> ● Meeting Logistics (location, date, time, etc.) ● Meeting content and structure ● Need for supplemental media or other resources to enhance content ● Need for transportation, childcare, and/or food ● Ground rules ● 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. 	<p>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 upon request.</p>
<p>G. Programs may create up-to-date, medically accurate print or electronic media that supplement the services provided.</p>	<p>G.1. Medical information included in print or electronic media created by the program will be reviewed by a medical professional for accuracy.</p>	<p>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.</p>
<p>H. It is recommended that sessions be facilitated by a person with lived experience pertaining to the purpose and focus of the group.</p>	<p>H.1. Facilitators should have the appropriate skills and training.</p>	<p>Personnel Files demonstrate facilitators’ experience, skills, and/or training.</p>

	<p>H.2. It is encouraged that participant facilitators be compensated.</p> <p>Compensation amount and type should be discussed with facilitators prior to beginning sessions.</p>	<p>Program’s Files demonstrate that participant facilitators were compensated (amount, date of facilitation, receipt of compensation)</p>
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Substance Use - 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 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 15 minutes or less

1 unit = methadone or other chemical treatment dispensing visit

1 unit = medical visit of 15 minutes or less

Service Components

STANDARD	MEASURE	DATA SOURCE
<p>A. Providers of substance use services must have the proper qualifications and expertise to deliver service.</p>	<p>A.1. In order to practice as a substance use counselor, one must qualify to perform the service under current Colorado mental health statutes (link here).</p> <p>Psychiatric services must be provided by a psychiatrist or a licensed psychiatric nurse practitioner, psychiatric physician’s assistant, or addiction medicine providers.</p>	<p>Personnel File details staff qualifications.</p>
	<p>A.2. Standards of supervision will be in compliance with current Colorado mental health statutes (link here)</p>	<p>Program’s Policies and Procedures indicate standards of supervision.</p>
<p>B. The program will utilize a mandatory disclosure form in compliance with Colorado mental health statutes.</p>	<p>B.1. Therapeutic disclosure will be reviewed and signed by all clients. At a minimum, the disclosure must include:</p> <ul style="list-style-type: none"> • Therapist’s name, degrees, credentials, certifications, and licenses; • Business address and business phone; • OBH description and contact information; • Treatment methods and techniques; • Options for second opinion; • Option to terminate therapy at any time; • Statement that in a professional relationship, sexual intimacy is never 	<p>Client’s File contains a copy of the disclosure.</p>

	<p>appropriate and should be reported to OBH;</p> <ul style="list-style-type: none"> Information about confidentiality and the legal limitations of confidentiality; and Space for the client and therapist's signature and date. 	
<p>C. Treatment will be offered in a timely manner.</p>	<p>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.</p>	<p>Client's File documents date of first contact or referral, and whether or not the client is in crisis.</p>
<p>D. A comprehensive evidence-based or best practices assessment shall be completed in a timely manner for each client.</p>	<p>D.1. The assessment will be completed upon admission and no later than seven business days after enrollment into services.</p>	<p>Client's File contains a comprehensive assessment.</p>
	<p>D.2. The assessment is completed in compliance with OBH regulations (link here) and ASAM criteria (link here)</p>	<p>Client's File contains a comprehensive assessment.</p>
<p>E. An initial service plan shall be developed with the client based on the comprehensive assessment.</p>	<p>E.1. The initial service plan will:</p> <ul style="list-style-type: none"> 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 Include specific, measurable, and attainable goals and objectives, with a realistic expected date(s) of achievement. 	<p>Client's File contains an initial service plan.</p>

	<p>E.2. The service plan will demonstrate that the client will get HIV medical care as medically indicated.</p>	<p>Client’s File contains service plan demonstrating client’s connection to HIV medical care.</p>
	<p>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.</p>	<p>Client’s File documents which if any medications are prescribed and potential interactions with HIV drugs.</p>
<p>F. All service plans will be reviewed and updated on a regular basis.</p>	<p>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:</p> <ul style="list-style-type: none"> • Medication assisted treatment: every 3 months; and • Outpatient: every 6 months. 	<p>Client’s File documents revisions of the service plan.</p>
	<p>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.</p>	<p>Client’s File documents revisions of the service plan.</p>
<p>G. The program must use evidence-based practices or care supported by empirical evidence.</p>	<p>G.1. The program uses evidence-based practices, including but not limited to:</p> <ul style="list-style-type: none"> • Motivational Interviewing; • Cognitive Behavioral Therapy; • Harm Reduction; • Relapse Prevention; • Trauma-Informed Treatment; and • Psychoeducation. 	<p>Program’s Policies and Procedures documents which practices are implemented.</p>
<p>H. Referrals made to services related to the</p>	<p>H.1. Referrals to qualified practitioners and/or services will occur, if clinically</p>	<p>Client’s File contains</p>

<p>service plan shall be made in a timely manner and documented.</p>	<p>indicated. If the client is in immediate crisis, they will be seen immediately, or proper referrals will be made.</p>	<p>documentation of any referrals.</p>
<p>I. Progress notes shall be completed after every contact with the client.</p>	<p>I.1. Progress notes should be a written chronological record, documented after every contact with the client.</p>	<p>Client's File contains progress notes.</p>
	<p>I.2. Progress notes should document:</p> <ul style="list-style-type: none"> • 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. 	
	<p>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.</p>	
<p>J. The program, at least once yearly, will assess client adherence to SAO/SU medications, SAO/SU appointments, HIV medical appointments and HIV medications.</p>	<p>J.1. The program will document adherence to SAO/SU and HIV medical appointments that are provided by the program and by other providers.</p>	<p>Client's File contains documentation of scheduled appointments and attendance.</p>
	<p>J.2. The program will document which SAO/SU and HIV medications they prescribe to the client, adherence to the medication schedule, and whether the client's substance use impacts medication adherence.</p>	<p>Client's File contains documentation of HIV medications and adherence.</p>
<p>K. Upon termination of active substance use services, a client case is closed and contains a closure summary</p>	<p>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</p>	<p>Client's File contains copy of closure summary if patient's case has been closed.</p>

<p>documenting the case disposition.</p>	<p>limited to the following information where applicable:</p> <ul style="list-style-type: none"> • 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; • Documentation of referrals and recommendations for follow-up care; and • Information regarding the death of the client. 	
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I. Brief Intervention Service Components

STANDARD	MEASURE	DATA SOURCE
<p>L. A substance use assessment will be completed at the first session.</p>	<p>L.1. A substance use assessment given the depth of interaction with the client will include, but is not limited to:</p> <ul style="list-style-type: none"> • Presenting problem; • Substance use history; and • Treatment history. 	<p>Client’s File contains a copy of the substance use assessment.</p>
<p>M. Every client shall have a treatment plan which guides their care.</p>	<p>M.1. All treatment plans will:</p>	<p>Client’s File contains copy of treatment plan. Treatment plan can be part of a</p>

	<ul style="list-style-type: none"> • Be based on the substance use assessment and 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. 	<p>session note or other EMR record.</p>
	<p>M.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.</p>	<p>Client’s File contains copy of treatment plan and prescribed medications.</p>
<p>N. The program will assess the client’s adherence to HIV medications.</p>	<p>N.1. The program will document which HIV medications the client is taking and adherence to medication schedule.</p>	<p>Client’s File contains documentation of HIV medications and adherence.</p>
<p>O. The program will refer to other services for ongoing care or psychiatric care as needed.</p>	<p>O.1. The program will document referrals to internal or external care and services.</p>	<p>Client’s File contains documentation of referrals.</p>
	<p>O.2. The program will maintain referral relationships with other programs.</p>	<p>Program’s Files contains documentation of referral relationships.</p>

Revision History

SERVICE CATEGORY	DATE OF REVISION
Definitions and Descriptions	
Acronyms	
Universal Standards	2/2/23
Case Management Continuum	
Childcare Services	1/5/23
Early Intervention Services	2/1/24
Emergency Financial Assistance	
Food Bank and Home-Delivered Meals	
Housing Services	
Linguistic Services	
Mental Health Services	2/1/24
Medical Transportation Services	
Oral Health Care Services	
Other Professional Services	
Psychosocial Support Services	1/5/23
Substance Use – Outpatient Care	



Exhibit G Federal Provisions

Ryan White Part A Funds

Federal Award ID (FAIN) #: H8900027
Federal Award Date: 05/16/2024
Federal Awarding Agency:
Department of Health and Human Services
Health Resources and Services Administration

Pass-Through Entity:
City & County of Denver
Department of Public Health and Environment (DDPHE)
101 W. Colfax Ave. Suite 800 Denver CO 80202

Contact Information forwarding official of the pass-through entity:
Robert George, Section Manager
Robert.George2@denvergov.org

Assistance Listing Number: 93.914
Federal Award Project Title: HIV Emergency Relief Project Grants

Total Federal funds obligated to subrecipient: \$840,161.00
Year 1 = \$425,898.00 – Ryan White Part A Funds
Year 2 = \$414,263.00 – Ryan White Part A Funds

Total amount of Federal Award: \$7,674,296.00

Was SAM.gov verified and search documented: Yes
