

STI/HIV Section
Care and Treatment Program



**Colorado Department
of Public Health
and Environment**

Contractor Program Monitoring
and Quality Improvement Form
(CPM/QI)

Contractor:

Contract Name:

Contract Effective Dates: through 04/01/2012/03/31/2013

Date this form was completed: / /

CDPHE Staff Member(s) who completed this form:

Summary Sheet – Contractor Ratings

	Quarter 1	Quarter 2	Quarter 3	Full Year
Section One - DELIVERABLES				
Part A – Service Objectives	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard
Part B – Service Delivery Data	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard
Part C – Client recruitment and referrals				<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard

Section Two – TIMELINESS	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard
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Section Three – QUALITY				
Part A – Quality Assurance				<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard
Part B – Capacity to deliver culturally competent services				<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard
Part C – Consumer involvement				<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard

	Quarter 1	Quarter 2	Quarter 3	Full Year
Part D – Confidentiality				<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard
Part E – Quality Improvement	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard
Part F – Sampling Client Records				<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard

Section Four – BUSINESS RELATIONS	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard
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Section One – DELIVERABLES

Part A – Service Objectives

Review the Quarterly Narrative and Data Progress Reports and complete the following table. Do NOT rate the Quality Improvement Objectives in this section; see Section Three, Part E, below. On a QUARTERLY basis, transfer overall ratings to the Summary Sheet on page i of this Form.

The following materials will be required to complete this part of the assessment:

1. The Quarterly Narrative Reports submitted by the Contractor year-to-date
2. The Quarterly Data Progress reports submitted by the Contractor year-to-date
3. Other documentation from the Contractor regarding performance on service objectives

Service Delivery Objective	Performance Rating on this objective	If contractor is BELOW STANDARD or ABOVE STANDARD, provide an explanation.
The Quarterly Narrative Reports submitted by the Contractor	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
Quarterly Data Progress Reports submitted by the Contractor	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
Rating for the narrative report , in terms of accuracy and completeness	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
Rating for the data report , in terms of accuracy and completeness	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	

Part B – Service Delivery Data

In the Table below, list every service that this contract funds. Provide ratings for each service and an explanation, if applicable. On a QUARTERLY basis, transfer overall ratings to the Summary Sheet on page i of this Form

The following materials will be required to complete this part of the assessment:

1. Data System information provided by the Contractor (Contractor Questionnaire, Section 1)
2. A listing of all funded services in the Contract
3. The Quarterly Reports submitted by the Contractor year-to-date
4. Service delivery reports from HELIX, Ryan White CAREWare, LabTracker, or other data system utilized by the Contractor to collect and report RSR/RDR data to CDPHE
5. For service units that appear too high or too low, additional documentation from the Contractor substantiating the data

✓ if funded	Service Category	Target number of unduplicated clients served during the reporting period	Target number of service units provided during the reporting period	Adequate justification for objectives that are more than 30% off target.	Explanation of any rating of BELOW or ABOVE standard
<input type="checkbox"/>	Case Management (Medical)	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
<input type="checkbox"/>	Case Management (non-Medical)	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
<input type="checkbox"/>	Child Care Services	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	

✓ if funded	Service Category	Target number of unduplicated clients served during the reporting period	Target number of service units provided during the reporting period	Adequate justification for objectives that are more than 30% off target.	Explanation of any rating of BELOW or ABOVE standard
<input type="checkbox"/>	Early Intervention Services	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
<input type="checkbox"/>	Emergency Financial Assistance	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
<input type="checkbox"/>	Food Bank/Home-Delivered Meals	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
<input type="checkbox"/>	Health Education/Risk Reduction	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
<input type="checkbox"/>	Health Insurance Premium & Cost Sharing Assistance	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
<input type="checkbox"/>	Home and Community-based Health Services	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	

✓ if funded	Service Category	Target number of unduplicated clients served during the reporting period	Target number of service units provided during the reporting period	Adequate justification for objectives that are more than 30% off target.	Explanation of any rating of BELOW or ABOVE standard
<input type="checkbox"/>	Home Health Care	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard		<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
<input type="checkbox"/>	Hospice Services	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard		<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
<input type="checkbox"/>	Housing Services	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard		<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
<input type="checkbox"/>	Legal Services	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard		<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
<input type="checkbox"/>	Linguistics Services	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard		<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
<input type="checkbox"/>	Medical Nutrition Therapy	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard		<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	

✓ if funded	Service Category	Target number of unduplicated clients served during the reporting period	Target number of service units provided during the reporting period	Adequate justification for objectives that are more than 30% off target.	Explanation of any rating of BELOW or ABOVE standard
<input type="checkbox"/>	Medical Transportation Services	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
<input type="checkbox"/>	Mental Health Services	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
<input type="checkbox"/>	Oral Health Care	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
<input type="checkbox"/>	Outpatient /Ambulatory Health Services	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
<input type="checkbox"/>	Outreach Services	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
<input type="checkbox"/>	Psychosocial Support Services	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	

✓ if funded	Service Category	Target number of unduplicated clients served during the reporting period	Target number of service units provided during the reporting period	Adequate justification for objectives that are more than 30% off target.	Explanation of any rating of BELOW or ABOVE standard
<input type="checkbox"/>	Referral for Health Care/ Supportive Services	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
<input type="checkbox"/>	Substance Abuse Services– Outpatient	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
<input type="checkbox"/>	Substance Abuse Services - Residential	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
<input type="checkbox"/>	Treatment Adherence Counseling	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
	Other _____ _____	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
	Other _____ _____	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	

Part C – Client recruitment and referrals

Rate the contractor on the following client recruitment/referral factors. Provide an explanation, if applicable. On a ANNUAL basis, transfer overall ratings to the Summary Sheet on page i of this Form

The following materials will be required to complete this part of the assessment:

1. Outreach and referral information (Contractor Questionnaire, Section 2).

Recruitment/Referral Factor	Overall performance rating on this factor	If contractor is BELOW STANDARD or ABOVE STANDARD, provide an explanation.
a. The Contractor utilizes outreach strategies to promote services to Ryan White eligible consumers.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
b. The Contractor tracks and evaluates its efforts to recruit potentially eligible clients.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
c. The Contractor analyzes the sources of referrals into its services and adjusts referral strategies accordingly.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
d. The Contractor has a well-developed protocol regarding referrals to other agencies/ services.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
e. The Contractor has a formal strategy to facilitate early intervention for newly diagnosed individuals.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	

Recruitment/Referral Factor	Overall performance rating on this factor	If contractor is BELOW STANDARD or ABOVE STANDARD, provide an explanation.
f. The Contractor has a formal strategy to facilitate early intervention for those who have never accessed care or who have lapsed from care.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	

Section Two – TIMELINESS

Rate the contractor on the following timeliness factors. Provide an explanation, if applicable. On a QUARTERLY basis, transfer overall ratings to the Summary Sheet on page i of this Form

The following materials will be required to complete this part of the assessment:

1. A log maintained by the Quality Monitor, showing requests for information and the timeliness of Contractor responses
2. Copies of the current Work Plan, which includes due dates for each objective
3. Reports from HELIX, Ryan White CAREWare, LabTracker, or other data system utilized by the Contractor to collect and report RSR/RDR data to CDPHE

Timeliness Factor	Overall performance rating on this factor	If contractor is BELOW STANDARD or ABOVE STANDARD, provide an explanation.
a. Contractor has entered or supplied performance data on or before deadlines (or within approved extensions)	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
b. Contractor has made steady progress toward meeting service delivery objectives	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
c. Contractor has responded to CDPHE requests for information	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	

Section Three – QUALITY

Part A – Quality Assurance

Rate the contractor on the following quality assurance factors. Provide an explanation, if applicable. On an ANNUAL basis, transfer overall ratings to the Summary Sheet on page i of this Form

The following materials will be required to complete this part of the assessment:

1. A listing of all staff funded fully or partially under this contract
2. An organizational chart supplied by the Contractor, showing lines of supervision
3. Supervisory notes supplied by the Contractor documenting observation of services, employee ratings, and follow up actions.
4. Client records/files showing sign-off by supervisors and follow up actions
5. Reports showing that data submitted to CDPHE was reviewed and approved by a supervisor
6. Training records supplied by the Contractor, showing a description of each training, the training date, and the staff attending
7. A description of quality assurance policies and procedures regarding volunteers

Quality Assurance Factor	Overall performance rating on this factor	If contractor is BELOW STANDARD or ABOVE STANDARD, provide an explanation.
a. The Contractor has clear lines of supervision for every staff person funded fully or partially funded under this contract.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
b. Supervisors are appropriately trained and experienced in the clinical area being supervised OR contracted clinical supervision is available.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	

Quality Assurance Factor	Overall performance rating on this factor	If contractor is BELOW STANDARD or ABOVE STANDARD, provide an explanation.
c. Staff who delivers services are acquainted with the Standards of Care.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
d. Supervisors routinely observe service delivery, rate employee performance according to Standards of Care, and take follow up action if needed.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
e. Supervisors routinely audit client records, provide sign-off, and take follow up action if needed.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
f. Supervisors routinely review data BEFORE it is submitted to CDPHE to ensure completeness and accuracy.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
g. Training is made available to staff based on identified needs or weaknesses.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
h. The Contractor has quality assurance processes for volunteers that mirror those for staff (training curricula, adequate supervision, follow up actions, etc.)	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	

Part B – Capacity to deliver culturally competent services

Rate the contractor on the following cultural competence factors. Provide an explanation, if applicable. On an ANNUAL basis, transfer overall ratings to the Summary Sheet on page i of this Form

The following materials will be required to complete this part of the assessment:

1. A Cultural Representation Grid completed by the Contractor, (Contractor Questionnaire, Section 3).
2. The federal LEP guidelines (Attachment A)
3. A description of linguistic capacity completed by the Contractor, (Contractor Questionnaire, Section 4).
4. Written policies and procedures regarding cultural competence supplied by the Contractor, including a description of who was involved in their development
5. Training records supplied by the Contractor, showing a description of each cultural competence training, the training date, and the staff attending

Cultural Competence Factor	Overall performance rating on this factor	If contractor is BELOW STANDARD or ABOVE STANDARD, provide an explanation.
a. The Contractor has made good faith effort to assemble a Board, Staff, and Volunteers that are reflective of the target audience in terms of race, gender, ethnicity, and sexual orientation.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
b. The Contractor has written policies and procedures for cultural competence in place.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
c. Policies and procedures were developed in collaboration with members of the target population	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
d. Staff are trained in cultural competence during their first year of employment	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	

Cultural Competence Factor	Overall performance rating on this factor	If contractor is BELOW STANDARD or ABOVE STANDARD, provide an explanation.
e. Staff attends a refresher course in cultural competence at least once every 5-year period	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
f. Translation services are provided in accordance with federal guidelines by one or more of the following means: by agency staff, by paid contractor, by telephone, or in written format. See Contractor Questionnaire, Section 4.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	

Part C – Consumer involvement

Rate the contractor on the following consumer involvement factors. Provide an explanation, if applicable. On an ANNUAL basis, transfer overall ratings to the Summary Sheet on page i of this Form

The following materials will be required to complete this part of the assessment:

1. The client feedback/grievance policy supplied by the Contractor
2. A description of consumer involvement (Contractor Questionnaire, Section 5).
3. Log of client grievances/feedback (Contractor Questionnaire, Section 6).

Consumer Involvement Factor	Overall performance rating on this factor	If contractor is BELOW STANDARD or ABOVE STANDARD, provide an explanation.
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Consumer Involvement Factor	Overall performance rating on this factor	If contractor is BELOW STANDARD or ABOVE STANDARD, provide an explanation.
a. The Contractor has a written client feedback/grievance policy and procedure, including client right to appeal to CDPHE	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
b. The Contractor prominently displays the client feedback/grievance procedure in way that informs all clients of their rights (e.g., a poster in the waiting area)	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
c. The Contractor documents all grievances received and appears to have made good faith effort to investigate and take appropriate action.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
d. The Contractor has an active consumer advisory group that meets at least annually.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
e. The consumer advisory group is reflective of the target population	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
f. The consumer advisory group selects its own membership and leadership	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
g. The consumer advisory group operates free from agency coercion or manipulation	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	

Consumer Involvement Factor	Overall performance rating on this factor	If contractor is BELOW STANDARD or ABOVE STANDARD, provide an explanation.
h. The recommendations of the consumer advisory group receive due consideration by the Contractor	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
i. The Contractor makes use of other methods to gain consumer involvement, such as surveys.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	

Part D – Confidentiality

Rate the contractor on the following confidentiality factors. Provide an explanation, if applicable. On an ANNUAL basis, transfer overall ratings to the Summary Sheet on page i of this Form

The following materials will be required to complete this part of the assessment:

1. A description of confidentiality policies and procedures (Contractor Questionnaire, Section 7).
2. Copies of the agency’s staff confidentiality agreement, confidentiality policy, and release of information form.

Confidentiality Factor	Overall performance rating on this factor	If contractor is BELOW STANDARD or ABOVE STANDARD, provide an explanation.
a. The Contractor has an adequate confidentiality policy that includes substantially all of the elements described in <u>Contractor Questionnaire</u> , Section 7.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	

Confidentiality Factor	Overall performance rating on this factor	If contractor is BELOW STANDARD or ABOVE STANDARD, provide an explanation.
b. Files containing confidential client information are locked.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
c. Access to client records is limited to those who have “need to know.”	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
d. The Contractor has protocols to protect computer based documents and records, including password protection for databases containing personal identifying information.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
e. All staff members and volunteers have a current confidentiality agreement on file.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
f. Breaches are investigated and appropriate actions are taken	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	

Part E – Quality Improvement

Rate the contractor on the following Quality Improvement factors. Provide an explanation, if applicable. On a QUARTERLY basis, transfer overall ratings to the Summary Sheet on page i of this Form.

The following materials will be required to complete this part of the assessment:

1. A copy of the most recent Quality Improvement Plan for the Contractor.
2. A copy of the Work Plan, including the Quality Improvement Goal (RSP and Medical Care Contractors only)
3. A membership list for the local Quality Team
4. Minutes of the meetings of the Quality Team
5. A description of the outcome of any Quality Improvement Efforts, such as Plan-Study-Do-Act efforts.

Quality Improvement Factor	Overall performance rating on this factor	If contractor is BELOW STANDARD or ABOVE STANDARD, provide an explanation.
a. The Contractor has assembled or continued a Quality Committee.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
b. The Quality Team adequately involves consumers.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
c. The Quality Committee has met at the frequency described in the Work Plan (quarterly, etc.).	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
d. The Contractor has a current Quality Plan and uses it to guide their quality improvement efforts.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
e. The Contractor utilizes data locally to monitor quality, and reports required QI data to CDPHE.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	

Quality Improvement Factor	Overall performance rating on this factor	If contractor is BELOW STANDARD or ABOVE STANDARD, provide an explanation.
f. The Contractor has implemented specific efforts to improve the quality of services, such as a PDSA (Plan, Do, Study, Act) initiative.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	

Part F – Sampling Client Records

Using the Statistical Sampling Chart (Attachment B), sample case management client records and summarize findings in the table below. Provide an explanation, if applicable. On an ANNUAL basis, transfer overall ratings to the Summary Sheet on page i of this Form.

The following materials will be required to complete this part of the assessment:

1. Access to client records
2. Completed copies of the Case File Review Form (Attachment C)
3. Contractor explanations of missing or erroneous items.

Findings of Case File Review	Overall performance rating on this factor	If contractor is BELOW STANDARD or ABOVE STANDARD, provide an explanation.
a. Client records were appropriately stored.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard <input type="checkbox"/> Not applicable	
b. Verification Eligibility	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard <input type="checkbox"/> Not applicable	

✓ if funded	Findings of Case File Review	Overall performance rating on this factor	If contractor is BELOW STANDARD or ABOVE STANDARD, provide an explanation.
<input type="checkbox"/>	Home Health Care	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard <input type="checkbox"/> Not applicable	
<input type="checkbox"/>	Hospice Services	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard <input type="checkbox"/> Not applicable	
<input type="checkbox"/>	Housing Services	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard <input type="checkbox"/> Not applicable	
<input type="checkbox"/>	Legal Services	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard <input type="checkbox"/> Not applicable	
<input type="checkbox"/>	Linguistics Services	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard <input type="checkbox"/> Not applicable	
<input type="checkbox"/>	Home Health Care	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard <input type="checkbox"/> Not applicable	

✓ if funded	Findings of Case File Review	Overall performance rating on this factor	If contractor is BELOW STANDARD or ABOVE STANDARD, provide an explanation.
<input type="checkbox"/>	Hospice Services	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard <input type="checkbox"/> Not applicable	
<input type="checkbox"/>	Housing Services	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard <input type="checkbox"/> Not applicable	
<input type="checkbox"/>	Legal Services	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard <input type="checkbox"/> Not applicable	
<input type="checkbox"/>	Linguistics Services	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard <input type="checkbox"/> Not applicable	
<input type="checkbox"/>	Medical Nutrition Therapy	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard <input type="checkbox"/> Not applicable	
<input type="checkbox"/>	Medical Transportation Services	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard <input type="checkbox"/> Not applicable	

✓ if funded	Findings of Case File Review	Overall performance rating on this factor	If contractor is BELOW STANDARD or ABOVE STANDARD, provide an explanation.
<input type="checkbox"/>	Mental Health Services	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard <input type="checkbox"/> Not applicable	
<input type="checkbox"/>	Oral Health Care	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard <input type="checkbox"/> Not applicable	
<input type="checkbox"/>	Outpatient /Ambulatory Health Services	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard <input type="checkbox"/> Not applicable	
<input type="checkbox"/>	Outreach Services	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard <input type="checkbox"/> Not applicable	
<input type="checkbox"/>	Psychosocial Support Services	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard <input type="checkbox"/> Not applicable	
<input type="checkbox"/>	Referral for Health Care/ Supportive Services	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard <input type="checkbox"/> Not applicable	

✓ if funded	Findings of Case File Review	Overall performance rating on this factor	If contractor is BELOW STANDARD or ABOVE STANDARD, provide an explanation.
<input type="checkbox"/>	Substance Abuse Services–Outpatient	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard <input type="checkbox"/> Not applicable	
<input type="checkbox"/>	Substance Abuse Services - Residential	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard <input type="checkbox"/> Not applicable	
<input type="checkbox"/>	Treatment Adherence Counseling	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard <input type="checkbox"/> Not applicable	

Section Four – BUSINESS RELATIONS

Rate the contractor on the following business relations factors. Provide an explanation, if applicable. On a QUARTERLY basis, transfer overall ratings to the Summary Sheet on page i of this Form

The following materials will be required to complete this part of the assessment:

1. Notation(s) of incidents compiled by the Quality Consultant regarding interactions with Contractor staff
2. Documentation by the Contractor of the level of customer service provided to their clients
3. Documentation by the Contractor of their business relations with collaborators and other stakeholders

Business Relations Factor	Overall performance rating on this factor	If contractor is BELOW STANDARD or ABOVE STANDARD, provide an explanation.
a. Contractor staff were courteous, cooperative, and professional in communications with CDPHE.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
b. Contractor representative(s) attempted to resolve problems in a timely manner and followed up with a status report.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	
c. Contractor kept the STI/HIV Section informed of circumstances that might negatively affect service delivery or product development	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	

Business Relations Factor	Overall performance rating on this factor	If contractor is BELOW STANDARD or ABOVE STANDARD, provide an explanation.
d. Contractor maintained good business relations with collaborators and other stakeholders.	<input type="checkbox"/> Above Standard <input type="checkbox"/> Meeting Standard <input type="checkbox"/> Below Standard	

Attachments

- Attachment A – Limited English Proficiency (LEP) Guidelines
- Attachment B – Statistical Sampling Chart
- Attachment C – Client Record Sampling Template RSP Providers
- Attachment D – Client Record Sampling Template Medical Providers
- Attachment E – Client Record Sampling Template HIAP Providers
- Attachment F – Client Record Sampling Template SBIRT Providers

Limited English Proficiency (LEP) Guidelines¹

LEP Guidelines apply if <u>at least one</u> of the following four items is selected (applies to both oral translations and written materials):	(Check all that apply)
1. Significant proportion of target population w/limited English proficiency;	<input type="checkbox"/>
2. Agency frequently encounters persons with limited English proficiency;	<input type="checkbox"/>
3. Important services are denied to this population;	<input type="checkbox"/>
4. Access could be reasonably provided with the resources available.	<input type="checkbox"/>

If any of 1-4, above, are checked, complete sections on oral/written translations.

<i>Oral Translations</i>		
Translation services are:	Yes	No
Provided by the agency	<input type="checkbox"/>	<input type="checkbox"/>
Confidential	<input type="checkbox"/>	<input type="checkbox"/>
Competent services provided:	Yes	No
In person via qualified staff and/or volunteers,	<input type="checkbox"/>	<input type="checkbox"/>
By telephone or other acceptable means	<input type="checkbox"/>	<input type="checkbox"/>
(If <i>Other</i> , describe:)		

<i>Written Material Translations</i>			
Agency provides written translations of documents for each eligible LEP group			
Projected # of clients for this program =			
≥ 100 people in LEP group and group is:		Yes	No
≥ 10% of projected clients: <u>ALL</u> documents translated for each group		<input type="checkbox"/>	<input type="checkbox"/>
10% LEP group 1:		Number in group 1:	
10% LEP group 2:		Number in group 2:	
≥ 100 people in LEP group and group is:		Yes	No
5-9% of projected clients: At least <u>vital documents</u> translated		<input type="checkbox"/>	<input type="checkbox"/>
5% LEP group a:		Number in group a:	
5% LEP group b:		Number in group b:	
< 100 people in LEP group		Yes	No
Agency provides written notice (in primary language of group) of right to receive competent oral interpretation of written materials, free of charge.		<input type="checkbox"/>	<input type="checkbox"/>
List groups:			

¹ <http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html>
 J:\HIV CT\Quality Team\Site Visits\FY12 HIV CT CPM QI Form v072012.docx Form version v072912

Attachment B -- Statistical Sampling Chart

Use the chart below to determine the number of client records/files that should be sampled as part of a site visit. This sampling is based on a 12% margin of error and an 80% confidence level.² If the first six client records sampled show evidence of adequate quality assurance practices (e.g., supervisor sign off on 100% of sample and no errors on documentation) then Column A may be used to determine the total sample size. Otherwise, Column B should be used to determine the total sample size. When possible, the sample should be stratified by contractor staff (e.g., four records per case manager).

Total Number of Client Records	<u>Column A</u> Minimum Sample Size if QA Adequate	<u>Column B</u> Minimum Sample Size if QA Inadequate
0 – 6	All	All
7 – 30	7	13 ³
31 – 50	9	17
51 – 70	10	20
71 – 90	11	22
91 – 110	11	23
111 – 130	12	24
131 – 150	12	24
151 – 170	13	25
171 – 190	13	25
191 – 210	13	26
211 – 230	13	26
231 – 250	13	26
251 – 270	13	26
271 – 290	13	26
291 – 310	14	27
311 – 330	14	27
331 – 350	14	27
351 – 370	14	27
371 – 390	14	27
391 – 410	14	27
411 – 500	14	27
501 – 750	14	28
751 – 1000	15	28
1001 or more	20	30

² <http://www.raosoft.com/samplesize.html>

³ Or total number of records, whichever is less.

Attachment C – CDPHE HIV Care and Treatment Program
Case File Review Form For Funded
Regional AIDS Service Providers (All Charts)

Agency:		Date Case File Audit	
Case File Review for Fiscal Year _____			
Program Monitor			

Please note that if a client chart review might prove to be an inaccurate assessment of the case manager in question (due to client being infrequently active, brevity of service at the agency, or other issue), another file may be selected at the discretion of the Program Monitor.

Random Case File review

eURN #							Number Compliant	Number reviewed	N/A
File was taken from a secure, locked cabinet/room or password protected electronic file.	<input type="checkbox"/>								
Date Chart/Case File Was Created:									
Eligibility Criteria									
Written Verification from Medical Professional OR Laboratory Data (HIV antibody test, viral HIV RNA)	<input type="checkbox"/>								
Documentation Proof of Colorado residency	<input type="checkbox"/>								
Name/eURN documented	<input type="checkbox"/>								
Date of client's first service visit documented	<input type="checkbox"/>								
Documentation of enrollment status at the end of the reporting period	<input type="checkbox"/>								
If the client's status is reported as "deceased", is the date of death documented.	<input type="checkbox"/>								
Client's year of birth	<input type="checkbox"/>								
Ethnicity documented	<input type="checkbox"/>								
Race documented	<input type="checkbox"/>								
Current Gender documented	<input type="checkbox"/>								
Client's income in terms of the percent of the Federal poverty level at the end of the reporting period documented	<input type="checkbox"/>								
The client's housing status at the end of the reporting period documented	<input type="checkbox"/>								
Zip Code documented	<input type="checkbox"/>								

eURN #							Number Compliant	Number reviewed	N/A
HIV/AIDS status of the client at the end of the reporting period documented	<input type="checkbox"/>								
If HIV/AIDS status is "CDC-defined AIDS," was the year of the client's AIDS diagnosis documented	<input type="checkbox"/>								
The client's risk factor for HIV infection documented	<input type="checkbox"/>								
The client's sources of health insurance during the reporting period documented	<input type="checkbox"/>								
Client reviewed and signed the Client Rights and Responsibilities Statement	<input type="checkbox"/>								
Client reviewed and signed a statement with the agency's Grievance Procedure	<input type="checkbox"/>								
Notes									
BRIEF CONTACT MANAGEMENT	<input type="checkbox"/>								
Last client contact by case manager:									
Was an acuity assessment completed	<input type="checkbox"/>								
Was the client assessed for medical needs	<input type="checkbox"/>								
Was the client assessed for psychosocial needs	<input type="checkbox"/>								
If referrals were made, documentation includes when referral was made	<input type="checkbox"/>								
NON-MEDICAL CASE MANAGEMENT	<input type="checkbox"/>								
Last 2 client contacts by case manager:									
Was an acuity assessment completed	<input type="checkbox"/>								
Was the client assessed for medical needs	<input type="checkbox"/>								
Was the client assessed for psychosocial needs	<input type="checkbox"/>								
Was the client assessed for possible HIV/STI risk behaviors	<input type="checkbox"/>								
Non-Medical Case Management Service Plan									
Was a Client Service Plan Developed	<input type="checkbox"/>								
Documentation includes short-term and long-term goals	<input type="checkbox"/>								

eURN #							Number Compliant	Number reviewed	N/A
Documentation includes action steps to address each goal	<input type="checkbox"/>								
Documentation includes specific services needed and referrals to be made	<input type="checkbox"/>								
Documentation includes a timeline completing goals	<input type="checkbox"/>								
Documentation includes progress made towards service plan	<input type="checkbox"/>								
Date of most recent revision of client service plan. Revision should occur as needed, but not less than annually									
Non-Medical Case Management Referral									
Documentation includes referral to named agency, contact person, address, instructions on how to make the appointment and what to bring	<input type="checkbox"/>								
Documentation includes all barriers identified in referral process and actions taken to resolve them	<input type="checkbox"/>								
Documentation includes follow-up activities and outcomes	<input type="checkbox"/>								
MEDICAL CASE MANAGEMENT	<input type="checkbox"/>								
Was an acuity assessment completed	<input type="checkbox"/>								
Was the client placed in medical case management based on acuity assessment	<input type="checkbox"/>								
Was the client assessed for medical care engagement	<input type="checkbox"/>								
Was the client assessed for possible mental health issues	<input type="checkbox"/>								
Was the client assessed for possible substance abuse issues	<input type="checkbox"/>								
Was the client assessed for possible HIV/STI risk behaviors	<input type="checkbox"/>								
Was the client re-assessed as needed, but not less than every 6 months	<input type="checkbox"/>								
Medical Case Management Service Plan									
Was a Client Service Plan Developed	<input type="checkbox"/>								

eURN #							Number Compliant	Number reviewed	N/A
Documentation includes short-term and long-term goals	<input type="checkbox"/>								
At least one goal in the service plan should address HIV risk behavior	<input type="checkbox"/>								
At least one goal should address adherence, if the client has been prescribed medication.	<input type="checkbox"/>								
Documentation includes action steps to address each goal	<input type="checkbox"/>								
Documentation includes specific services needed and referrals to be made	<input type="checkbox"/>								
Documentation includes a timeline completing goals	<input type="checkbox"/>								
Documentation includes a plan for follow-up each goal	<input type="checkbox"/>								
Date of most recent revision of client service plan. Revision should occur as needed, but not less than every 6 months									
Last 3 client contacts by case manager:									
Note type of Client contact for the last 3 contacts (phone, face-to-face, home visit, letter)									
Medical Case Management Referral									
Documentation includes referral to named agency, contact person, address, instructions on how to make the appointment and what to bring	<input type="checkbox"/>								
Documentation includes all barriers identified in referral process and actions taken to resolve them	<input type="checkbox"/>								
Documentation includes follow-up activities and outcomes. Contractor has a tracking mechanism to monitor completion of all active referrals.	<input type="checkbox"/>								
Medical Case Management Medical Coordination									
Does the Case File (data system) annotate the most recent medical visit?	<input type="checkbox"/>								

eURN #							Number Compliant	Number reviewed	N/A
Date of the most recent medical visit									
Name of the Medical Provider									
Does the Case File (data system) note the clients' current medications?	<input type="checkbox"/>								
Does the Case File (data system) note any inoculations, screenings, and immunizations	<input type="checkbox"/>								
Documentation of T cell count	<input type="checkbox"/>								
Documentation of when the last T cell count was done	<input type="checkbox"/>								
Documentation of Viral Load	<input type="checkbox"/>								
Documentation of when the last Viral Load was done	<input type="checkbox"/>								
Documentation T cell count and viral load was provided by a medical provider	<input type="checkbox"/>								
Documentation of timely case conferencing with key providers	<input type="checkbox"/>								
Medical Case Management Adherence									
Was an Adherence Plan Developed	<input type="checkbox"/>								
The written Adherence Plan includes documentation of treatment education, side effect management nutritional counseling use of reminder tools motivational interviewing in support of mental health and substance abuse counseling relapse prevention and management strategies, practical strategies that support adherence.	<input type="checkbox"/>								
Pharmacy pick-up and clinic visit history documented	<input type="checkbox"/>								
Documentation of prescribed medications including date prescribed, dosages and frequency of current medications in client record	<input type="checkbox"/>								
Documentation includes referrals made to other needed services to support adherence	<input type="checkbox"/>								

eURN #							Number Compliant	Number reviewed	N/A
Notes:									
FOOD BANK	<input type="checkbox"/>								
Documentation of client received vouchers or food disbursements	<input type="checkbox"/>								
Documentation of the Number of vouchers or food disbursements given	<input type="checkbox"/>								
Documentation of the distributed food is present in the agency food log and available for review.							<input type="checkbox"/> Reviewed	<input type="checkbox"/> unavailable	
Agency will have Documentation of written policies and procedures on the distribution of foods and available for review.							<input type="checkbox"/> Reviewed	<input type="checkbox"/> unavailable	
MEDICAL TRANSPORTATION	<input type="checkbox"/>								
Documentation of client received vouchers or tokens	<input type="checkbox"/>								
Documentation of the Number of vouchers or tokens	<input type="checkbox"/>								
Documentation transportation assistance is related to medical or support service appointment	<input type="checkbox"/>								
FINACIAL ASSISTANCE	<input type="checkbox"/>								
Documentation that income eligibility criteria was followed	<input type="checkbox"/>								
Purpose of each request documented	<input type="checkbox"/>								
Cause of shortfall documented	<input type="checkbox"/>								
Documentation that limitation on usage guidelines was followed (Utilities, Health Insurance, HIV related Medication or HIV related medical care)	<input type="checkbox"/>								
Documentation that limitation on amount guidelines was followed The total of all assistance did not exceed the	<input type="checkbox"/>								

eURN #							Number Compliant	Number reviewed	N/A
maximum amount of \$1,000									
Documentation that No payment may be made directly to clients, family or household members.	<input type="checkbox"/>								
Is there documentation (including name of the agency, type of denial, date of request and denial) that other sources of non-Ryan White funding/service were pursued for each granted request?	<input type="checkbox"/>								
Was a financial plan developed to eliminate the need emergency assistance services	<input type="checkbox"/>								
ORAL HEALTH	<input type="checkbox"/>								
Documentation of oral health care voucher or direct payment arrangement	<input type="checkbox"/>								
Copy of client Treatment Plan on file	<input type="checkbox"/>								
Is there documentation (including name of the agency, type of denial, date of request and denial) that other sources of non-Ryan White funding/service were pursued for each granted request?	<input type="checkbox"/>								
Documentation that limitation on amount guidelines was followed The total of all assistance did not exceed the maximum amount of \$1,000	<input type="checkbox"/>								
MENTAL HEALTH	<input type="checkbox"/>								
Was a biopsychosocial assessment completed	<input type="checkbox"/>								
Date of assessment									
Was a Client Treatment Plan Developed	<input type="checkbox"/>								
Was a Client Goals Developed	<input type="checkbox"/>								
Client progress notes documented	<input type="checkbox"/>								
Documentation includes referrals made	<input type="checkbox"/>								
MEDICAL NUTRITION	<input type="checkbox"/>								
Documentation includes written prescription for	<input type="checkbox"/>								

eURN #							Number Compliant	Number reviewed	N/A
medical nutrition									
Was an assessment of client's nutritional needs completed	<input type="checkbox"/>								
Nutrition Plan Developed	<input type="checkbox"/>								
Medical nutrition services provided by licensed, registered dietician	<input type="checkbox"/>								
HOUSING	<input type="checkbox"/>								
Documentation that income eligibility criteria was followed	<input type="checkbox"/>								
Copy of lease, default or late payment notices	<input type="checkbox"/>								
The total of all assistance did not exceed the maximum amount of \$1,000	<input type="checkbox"/>								
Is there documentation (including name of the agency, type of denial, date of request and denial) that other sources of non-Ryan White funding/service were pursued for each granted request?	<input type="checkbox"/>								
Was a stable housing plan developed to eliminate the need emergency housing assistance services	<input type="checkbox"/>								
Notes:									

Attachment D – CDPHE HIV Care and Treatment Program
Case File Review Form For Funded
Medical Ryan White Services (All Charts)

Agency:		Date Case File Audit	
Contract Effective Dates	-		

Please note that if a client chart review might prove to be an inaccurate assessment of the Provider in question (due to client being infrequently active, brevity of service at the agency, or other issue), another file may be selected at the discretion of the Program Monitor.

Random Case File review

eURN #							Number Compliant	Number reviewed	N/A
File was taken from a secure, locked cabinet/room or password protected electronic file.	<input type="checkbox"/>								
Date Chart/Case File Was Created:									
Eligibility Criteria									
Written Verification from Medical Professional	<input type="checkbox"/>								
Laboratory Data (HIV antibody test, viral HIV RNA)	<input type="checkbox"/>								
Documentation Proof of Residence in the appropriate service area:	<input type="checkbox"/>								
Name/eURN documented	<input type="checkbox"/>								
Date of client's first service visit documented	<input type="checkbox"/>								
Documentation of enrollment status at the end of the reporting period	<input type="checkbox"/>								
If the client's status is reported as "deceased", is the date of death documented. documented.	<input type="checkbox"/>								
Client's year of birth	<input type="checkbox"/>								
Ethnicity documented	<input type="checkbox"/>								
Race documented	<input type="checkbox"/>								
Current Gender documented	<input type="checkbox"/>								
Client's income in terms of the percent of the Federal poverty level at the end of the reporting period documented	<input type="checkbox"/>								
The client's housing status at the end of the reporting period documented	<input type="checkbox"/>								

Zip Code documented	<input type="checkbox"/>								
HIV/AIDS status of the client at the end of the reporting period documented	<input type="checkbox"/>								
If HIV/AIDS status is "CDC-defined AIDS," was the year of the client's AIDS diagnosis documented	<input type="checkbox"/>								
The client's risk factor for HIV infection documented	<input type="checkbox"/>								
The client's sources of health insurance during the reporting period documented	<input type="checkbox"/>								
Client reviewed and signed the Client Rights and Responsibilities Statement	<input type="checkbox"/>								
Client reviewed and signed a statement with the agency's Grievance Procedure	<input type="checkbox"/>								
Notes									
Tracks number of visits for each funded core service	<input type="checkbox"/>								
Tracks number of visits for each funded support service	<input type="checkbox"/>								
HIV risk reduction screening/counseling documented	<input type="checkbox"/>								
All dates of the client's outpatient/ambulatory care visits documented	<input type="checkbox"/>								
The value and test date for all CD4 count tests administered to the client during the reporting period documented.	<input type="checkbox"/>								
The value and test date for all viral load tests administered to the client during the reporting period documented	<input type="checkbox"/>								
PCP Prophylaxis given or not medically indicated documented	<input type="checkbox"/>								
Was the client prescribed HAART at any time in this reporting period or not medically indicated documented?	<input type="checkbox"/>								
The client was screened for tuberculosis (TB) during the reporting period or not medically indicated documented?	<input type="checkbox"/>								

If the response to Item above is "no" or "not medically indicated," indicate if the client has been screened for TB since his or her HIV diagnosis.	<input type="checkbox"/>								
Has the client been screened for syphilis during this reporting period?	<input type="checkbox"/>								
Was the client screened for Hepatitis B during this reporting period?	<input type="checkbox"/>								
If response is "no" or "not medically indicated" in the item above, then answer: Was the client screened for Hepatitis B since his/her HIV diagnosis?	<input type="checkbox"/>								
Has the client completed the vaccine series for Hepatitis B?	<input type="checkbox"/>								
Was the client screened for Hepatitis C during this reporting period?	<input type="checkbox"/>								
If response is no" or "not medically indicated" in the item above, then answer: Has the client been screened for Hepatitis C since his/her HIV diagnosis?	<input type="checkbox"/>								
Was the client screened for substance use (alcohol and drugs) during this reporting period?	<input type="checkbox"/>								
Was the client screened for mental health during this reporting period?	<input type="checkbox"/>								
For HIV+ women only: Did the client receive a Pap smear during this reporting period?	<input type="checkbox"/>								
For HIV+ women only: Was the client pregnant during the reporting period?	<input type="checkbox"/>								
Notes									

Attachment E – CDPHE HIV Care and Treatment Program
Case File Review Form for HIAP
Insurance Assistance Services (All Charts)

Agency:		Date Case File Audit	
Contract Effective Dates	-		
Number of Active Members Served:	Target Number to be Reviewed		

Please note that if a client chart review might prove to be an inaccurate assessment of the HIAP eligibility worker in question (due to client being infrequently active, brevity of service at the agency, or other issue), another file may be selected at the discretion of the Program Monitor.

Random Case File review:

eURN #								Number Compliant	Number reviewed	N/A
File was taken from a secure, locked cabinet/room or password protected electronic file.	<input type="checkbox"/>									
Date Chart/Case File Was Created:										
Eligibility Criteria										
Written Verification from Medical Professional (or Laboratory Data (HIV antibody test, viral HIV RNA)	<input type="checkbox"/>									
Documentation Proof of Residence in the appropriate service area:	<input type="checkbox"/>									
Name/eURN documented	<input type="checkbox"/>									
Date of client's first service visit documented	<input type="checkbox"/>									
Documentation of enrollment status at the end of the reporting period	<input type="checkbox"/>									
If the client's status is reported as "deceased", is the date of death documented.	<input type="checkbox"/>									
Client's year of birth	<input type="checkbox"/>									
Ethnicity documented	<input type="checkbox"/>									
Race documented	<input type="checkbox"/>									
Current Gender documented	<input type="checkbox"/>									
Client's income in terms of the percent of the Federal poverty level at the end of the reporting period documented	<input type="checkbox"/>									
The client's housing status at the end of the reporting period documented	<input type="checkbox"/>									

Zip Code documented	<input type="checkbox"/>								
HIV/AIDS status of the client at the end of the reporting period documented	<input type="checkbox"/>								
If HIV/AIDS status is "CDC-defined AIDS," was the year of the client's AIDS diagnosis documented	<input type="checkbox"/>								
The client's risk factor for HIV infection documented	<input type="checkbox"/>								
The client's sources of health insurance during the reporting period documented	<input type="checkbox"/>								
Client reviewed and signed the Client Rights and Responsibilities Statement	<input type="checkbox"/>								
Client reviewed and signed a statement with the agency's Grievance Procedure	<input type="checkbox"/>								
Notes:									
HIV Insurance Assistance Program (HIAP)									
Documentation that client meets ADAP eligibility criteria	<input type="checkbox"/>								
ADAP form completely filled out	<input type="checkbox"/>								
ADAP form complete and accurately entered into Ramsell (after May 2011)	<input type="checkbox"/>								
Insurance plan properly evaluated	<input type="checkbox"/>								
Documentation of the private plan for which the applicant may be eligible (employer, COBRA, spouse plan)	<input type="checkbox"/>								
Documentation that the private plan was creditable (i.e., adequate enough)	<input type="checkbox"/>								
Documentation that Medicare eligibility was properly assessed, with appropriate follow up	<input type="checkbox"/>								

Documentation that Medicaid eligibility was properly assessed, with appropriate follow up	<input type="checkbox"/>								
Documentation that other third party payment source was assessed (VA, Indian Health), with appropriate follow up	<input type="checkbox"/>								
HIAP eligibility criteria									
Proper assignment to Level 1 or Level 2	<input type="checkbox"/>								
Estimation of annual costs and planning of allocation of benefit between premium and out-of-pocket costs	<input type="checkbox"/>								
Copy of Insurance ID card	<input type="checkbox"/>								
Proof of insurance billing	<input type="checkbox"/>								
Qualifications/Guidelines form	<input type="checkbox"/>								
Notes:									

Attachment F – CDPHE HIV Care and Treatment Program
Case File Review Form For Funded
SBIRT Services (All Charts)

Agency:		Date Case File Audit	
Case File Review for Fiscal Year _____			
Program Monitor			

SBIRT CHARTS

Please note that if a client chart review might prove to be an inaccurate assessment of the SBIRT Provider in question (due to client being infrequently active, brevity of service at the agency, or other issue), another file may be selected at the discretion of the Program Monitor.

Random Case File review

eURN #								Number Compliant	Number reviewed	N/A
Date Chart/Case File Was Created:										
Client reviewed and signed Consent	<input type="checkbox"/>									
Eligibility Criteria										
Written Verification from Medical Professional OR Laboratory Data (HIV antibody test, viral HIV RNA)	<input type="checkbox"/>									
Documentation Proof of Residence in the appropriate service area:	<input type="checkbox"/>									
Name/eURN documented	<input type="checkbox"/>									
Date of client's first service visit documented	<input type="checkbox"/>									
Documentation of enrollment status at the end of the reporting period	<input type="checkbox"/>									
If the client's status is reported as "deceased", is the date of death documented.	<input type="checkbox"/>									
Client's year of birth	<input type="checkbox"/>									
Ethnicity documented	<input type="checkbox"/>									
Race documented	<input type="checkbox"/>									
Current Gender documented	<input type="checkbox"/>									
Client's income in terms of the percent of the Federal poverty level at the end of the reporting period documented	<input type="checkbox"/>									
The client's housing status at the end of the	<input type="checkbox"/>									

eURN #							Number Compliant	Number reviewed	N/A
reporting period documented									
Zip Code documented	<input type="checkbox"/>								
HIV/AIDS status of the client at the end of the reporting period documented	<input type="checkbox"/>								
If HIV/AIDS status is "CDC-defined AIDS," was the year of the client's AIDS diagnosis documented	<input type="checkbox"/>								
The client's risk factor for HIV infection documented	<input type="checkbox"/>								
The client's sources of health insurance during the reporting period documented	<input type="checkbox"/>								
Client reviewed and signed the Client Rights and Responsibilities Statement	<input type="checkbox"/>								
Client reviewed and signed a statement with the agency's Grievance Procedure	<input type="checkbox"/>								
ASSIST									
ASSIST Completed	<input type="checkbox"/>								
Screening results Documented	<input type="checkbox"/>								
Was a Client offered appropriate treatment based on results	<input type="checkbox"/>								
ASSIT indicates a need for Brief Intervention	<input type="checkbox"/>								
Were client goals developed	<input type="checkbox"/>								
Client progress documented	<input type="checkbox"/>								
ASSIT indicates a need for Brief Therapy	<input type="checkbox"/>								
Was the client referred to a substance abuse provider for brief therapy	<input type="checkbox"/>								
Was the follow up on referrals documented	<input type="checkbox"/>								
Brief Therapy provided by a licensed therapist	<input type="checkbox"/>								
Were client goals developed	<input type="checkbox"/>								
Client progress documented	<input type="checkbox"/>								
ASSIT indicates a need	<input type="checkbox"/>								

eURN #							Number Compliant	Number reviewed	N/A
for Referrals									
Was the client referred to a substance abuse provider for treatment	<input type="checkbox"/>								
Was the follow up on referrals documented	<input type="checkbox"/>								