Ryan White Program
Service Area Standards: Outpatient Ambulatory Care

HRSA Definition: Outpatient/Ambulatory Health Services provide diagnostic and therapeutic-related activities directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings may include: clinics, medical offices, mobile vans, using telehealth technology, and urgent care facilities for HIV-related visits. Allowable activities include:

- Medical history taking
- Physical examination
- Diagnostic testing (including HIV confirmatory and viral load testing), as well as laboratory
- testing
- 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
- Referral to and provision of specialty care related to HIV diagnosis, including audiology and ophthalmology

Program Guidance: Treatment adherence activities provided during an Outpatient/Ambulatory Health Service visit are considered Outpatient/Ambulatory Health Services, whereas treatment adherence activities provided during a Medical Case Management visit are considered Medical Case Management services.

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.

All subrecipients must meet universal standards requirements in addition to service area standards for which they are funded.

Standard	Measure	Data Source
Consumer's medical care initial encounter and subsequent visit shall be in compliance with the current U.S. Department of Health & Human Services Guidelines and/or the International Antiviral Society General Medicine Primary Care Guide. http://aidsinfo.nih.gov/guidelines https://www.iasusa.org/guidelines	See section on Provision of Services and Consumer records	File reviews/site visits
License, credentials, and experience/education • All clinicians and staff maintain appropriate licenses and credentials. • Clinicians must be HIV-experienced. (Have treated 50 or more individuals living with HIV.)	Completed forms on file for all participating clinicians, including Minnesota Medical License and other appropriate licenses and certifications.	File Reviews/Site Visits
• Appropriate specialty care services shall be provided as indicated. • Agencies shall have a written policy for making specialty care referrals. • Agencies shall develop and maintain a relationship with specialty care providers.	Policies and procedures in place Copy of MOU on file.	File Reviews/Site Visits
• Agencies shall ensure that required documentation is obtained and maintained. • Provision of Services and Consumer Records shall include: o The initial comprehensive assessment that includes physical, sociocultural and emotional assessments and may require two to three outpatient visits to complete. (See Appendix I) o Follow-up visits for patients receiving ARV therapy should be scheduled every three to four months, except at the practitioner's discretion when a patient has demonstrated long term stability and adherence in his/her medical regime. Follow-up visits should be scheduled every six to twelve months for patients who are not receiving ARV therapy. Follow-up visits	Documentation in client files.	File Review/Site Visits

Standard	Measure	Data Source
should be scheduled more frequently at entry to care, when starting or changing ARV regimens, or for management of acute problems. (See Appendix II)		
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Appendix I

From Los Angeles County Commission on HIV Standards of Care Medical Outpatient Services
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Initial Assessment and Reassessment. The initial assessment of HIV-infected individuals must be comprehensive in its scope, including physical, sociocultural and emotional assessments and may require two to three outpatient visits to complete. Unless indicated more frequently by a patient's changing health condition, a comprehensive reassessment should be completed on an annual basis. The Medical Outpatient practitioners (physician, NP, PA or RN) responsible for completing the initial assessment and reassessments will utilize assessment tools based on established HIV practice guidelines. While taking steps to ensure a patient's confidentiality, the results of these assessments will be shared with medical care coordination programs, as appropriate. An initial assessment and annual reassessment for HIV-infected patient should include a general medical history; a comprehensive HIV-related history, including a psychosocial history; sexual and substance abuse histories; and a comprehensive physical examination. When obtaining the patient's history, the practitioner should use vocabulary that the patient can understand, regardless of education level.

General Medical Histories should include (at minimum):

□ History of present illness □ Past hospitalizations, past and current illnesses □ Past immunizations □ Travel history and place of birth □ Current treatment, prescription and non-prescription medicines (including complementary and alternative therapies, illicit substances and hormones)	□ Pets/animal exposures □ Allergies □ Full review of systems □ Mental health □ Health Literacy □ Occupational history and hobbies

Comprehensive HIV-related histories should include (at minimum):

□ HIV treatment history and staging □ Most recent viral load and CD4 count □ Nadir CD4 and peak viral load □ Current and previous ARV regimens □ Previous adverse ARV drug reactions □ Previous adverse reactions to drugs used for opportunistic infection prophylaxis □ History of HIV-related illness and opportunistic infections □ History of sexually transmitted diseases □ History of tuberculosis □ History of hepatitis and hepatitis vaccines □ Psychiatric history □ Diagnosed psychiatric diseases □ Previous/current treatment for psychiatric diseases □ Disability related to psychiatric disease □ Homicidality and suicidality □ Socio-cultural assessment □ Transfusion or blood product history, especially before 1985 □ Review of sources of past medical care (obtaining past medical records whenever possible) □ Sexual history o Sexual activity o Sexual practices o Gender identity o Past and current partners o Risk behavior assessment	□ HIV-specific review of systems • Skin • Eyes • Ear, nose and throat • Stomatognathic • Pulmonary • Cardiovascular • Gastrointestinal/Hepatic • Endocrine • Genitourinary • OB/GYN • Dermatologic • Musculoskeletal • Neurologic • Hematopoietic • Metabolic □ Substance use history • Past and current use and types of drugs, including alcohol • Frequency of use and usual route of administration • Risk behavior assessment • History of treatment □ Tobacco use history

Comprehensive Physical Exams should include (at minimum):

□ Temperature, vital signs, height and weight □ Pain assessment □ Ophthalmologic examination □ Ears, nose, and throat examination	□ Pulmonary examination □ Cardiac examination □ Abdominal examination □ Genital examination

□ Dermatological examination □ Lymph node examination □ Oral examination	□ Rectal examination □ Neurological examination

Appendix II

From Los Angeles County Commission on HIV Standards of Care Medical Outpatient Services
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Follow-up Visits. At minimum, a medical visit for a returning patient will include a problem focused history, problem focused examination and straightforward medical decision-making. Follow-up visits should record and address:

- □ Temperature, vital signs, height and weight
- □ Problems list status and updates
- □ Pain assessment
- □ Adherence with the treatment plan
- □ Viral load measurements (see Laboratory Assessment and Diagnostic Screening below), viral load should be measured according to prevailing medical standards and current guidelines.
- □ Resistance testing should be performed (if feasible) for patients when viral failure to ARV has been demonstrated and/or when sub-optimal suppression of viral load occurs (see more detailed discussion in Drug Resistance Testing which follows)
- □ Laboratory tests as outlined in Laboratory Assessment and Diagnostic Screening below
- □ Prophylaxis for opportunistic infections offered to each patient as indicated by immune status. Refer to current guidelines and prevailing standards for prophylaxis of opportunistic infections from DHHS Guidelines for Opportunistic Infections (www.aidsinfo.nih.gov/). Documentation of current therapies should be maintained on all patients receiving prophylaxis.
- □ HIV-infected women should have a documented cervical Pap smear dated within the last year. Normal smears should be followed with a second smear in six months. If both results are negative, subsequent Pap smears should be performed annually. Smears showing severe inflammation or reactive changes should be reevaluated within three to six months. Diagnosis of SIL or atypical squamous cells of undetermined significance should be followed with colposcopic examination of the lower genital tract. Inquire about last menstrual period and contraception, when appropriate. Regular discussions of family planning and contraception shall occur with
- □ Anal and rectal exams should be performed at least annually. Baseline and periodic anal pap smears for high-risk populations should be considered, with appropriate referral to specialists for those patients receiving positive results. (As this is an area of emerging data, any newly adopted national guidelines are recommended if/when they are disseminated).
- □ For patients who have no history of TB or positive PPD tests, a PPD test or Interferon Gamma Release Assay (IGRA) should be performed at least annually, with results recorded. Record attempts to follow up with patients who do not return for PPD reading. For all positive IGRA tests and PPD tests of at least five millimeters of induration, a chest x-ray should be obtained to rule out active pulmonary disease, and, if appropriate, prophylaxis should be given. If there is a history of a positive PPD or IGRA, the history of prophylactic treatment should be recorded in the chart. Risk for TB should be assessed annually.
- □ Advance directives, durable powers of attorney, living wills and other planning documents, including POLST (Physician's Orders for Life Sustaining Treatment) and DNR (Do Not Resuscitate) status, should be addressed at the beginning of treatment and at any appropriate time in the course of the illness.

- □ Patients with CD4 counts below 50 should be referred for ophthalmic examination by a trained retinal specialist for screening or as recommended by that specialist, according to prevailing medical standards and current guidelines. Follow-up should be conducted as recommended by the specialist or clinical judgment.
- □ Documentation of discussions of safer sex practices for both men and women.
- □ Following standards of care for HIV prevention and treatment, MO practitioners must include the following in each patient encounter:
- □ Providing brief HIV prevention messages (asking patients about risk behaviors, and positively reinforcing patient's report of risk reduction behavior)
- □ Asking patients about problems and concerns with treatment adherence and making suggestions to support adherence
- □ Screening patients' nutritional needs and referring them for medical nutrition therapy services when and as needed.
- □ Asking patients about their social living conditions, ensuring that lack of housing, food, or other social needs do not become a barrier to treatment adherence
- □ Providing patient education on HIV disease, symptoms, medications and treatment regimens to increase patient participation in treatment decision-making (see www.IHI.org for Institute for Healthcare Improvement guidelines on "Self-Management"). Patient education on medications will include instructions, risks and benefits, compliance, side effects and drug interaction.
- □ Building and maintaining patient relationships, increasing the likelihood that patients may ask for needed emotional support, or talk with practitioners about substance abuse issues.

Laboratory Assessment and Diagnostic Screening (including Drug Resistance Screening). Medical Outpatient programs must have access to all laboratory services required to comply fully with established practice guidelines for HIV prevention and risk reduction and for the clinical management of HIV disease. Programs must assure timely, quality lab results, readily available for review in medical encounters.

Baseline lab tests (preferably at fasting) for all HIV positive persons should include:

□ CBC	□ Syphilis serology and urine GC/Chlamydia
□ Liver function tests	□ *Toxoplasma gondii* antibody screening
□ BUN	□ Urinalysis
□ Creatinine	□ CD4 count and HIV-RNA viral load
□ Protein	□ Chest x-ray
□ Albumin	□ PPD
□ Glucose	□ Cervical Pap smear (if not done in past year)
□ Triglycerides	□ Hepatitis A screening for those not previously vaccinated
□ Cholesterol	□ Hepatitis B and C serology*

*If the serology for Hepatitis C is reactive, then tests to determine whether the patient has chronic Hepatitis C infection should be done. If a quantitative Hepatitis C viral load is indicated, and if the virus is present, the patient should be counseled and evaluated for hepatitis treatment and, as appropriate, treatment should be initiated.

Follow-up and ongoing lab tests for patients should include, at a minimum:

- □ **Annual:** CBC, liver function tests, BUN, cholesterol, triglycerides (preferably fasting)
- □ **Every six months**: HIV-RNA, Syphilis serology and urine GC/Chlamydia for sexually active patients at increased risk
- □ In accordance with Public Health Standard guidelines follow-up and ongoing lab tests for patients **on ARV** should include: CBC, liver function tests, BUN, creatinine, glucose, cholesterol, triglycerides (preferably fasting), HIV-RNA and Syphilis serology. Urine GC/Chlamydia should be offered for sexually active patients at increased risk.

*Frequency of CD4 count monitoring based most current U.S. Department of Health and Human Services (HHS) guidelines.

Drug Resistance Testing. When appropriate, medical outpatient practitioners may order drug resistance testing to measure a patient's pattern of resistance of HIV to antiretroviral medications. Genotypic testing looks for viral mutations, and is expected for all naïve patients, and phenotypic testing measures the amount of drug needed to suppress replication of HIV. By utilizing resistance testing, practitioners can determine if the virus is likely to be suppressed by each antiretroviral drug. This information is used to guide practitioners in prescribing the most effective drug combinations for treatment.
Drug resistance testing services will be based upon most recent established guidelines and standards of care including the PHS Guidelines and the Infectious Disease Society of America Guidelines, as well as the DHHS Panel on Antiretroviral Guidelines for Adults and Adolescents' *Recommendations for HIV Viral Load Testing* and the California Department of Health Services' *Recommended General Clinical Guidelines*. Practitioners are directed to HIV Resistance Web at www.HIVRESITANCEWEB.com for *Ask the Experts;* and www.thebody.com for the Forum on Drug Resistance and Staying Undetectable for more information.

Counseling and education about drug resistance testing must be provided by the patient's medical practitioner, registered nurse and/or other appropriate licensed healthcare provider (if designated by the practitioner). Patients must be fully educated about their medical needs and treatment options according to standards of medical care. Patients must be given an opportunity to ask questions about their immune system, antiretroviral therapies and drug resistance testing. All patient education efforts will be documented in the patient record.