RYAN WHITE PART A (RWPA) HIV/AIDS PROGRAM
LAS VEGAS TRANSITIONAL GRANT AREA (TGA)

OUTPATIENT/AMBULATORY HEALTH SERVICES-SERVICE STANDARDS

Drafted by Part A Recipient Office	Approved by Part A Planning Council
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IMPORTANT: All Las Vegas Transitional Grant Area (TGA) service providers must adhere to the Las Vegas-TGA *Universal Service Standards*. Please read the *Universal Service Standards* prior to reading the service standards below.

Service Description

Outpatient/Ambulatory Health Services are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight. Emergency room or urgent care services and not considered outpatient settings. Allowable activities include:

- Medical history taking
- Physical examination
- Diagnostic testing, including laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventative care and screening
- Pediatric development 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

Program Guidance

Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category whereas Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category.

See Policy Notice 13-04: Clarifications Regarding Clients Eligibility for Private Health Insurance and Coverage of Services by Ryan White HIV/AIDS Program *See* Early Intervention Services

See Early Intervention Services

Minimum Requirements

STANDARD	MEASURE
1. Staff Requirements	
A. Outpatient Ambulatory Health Services program staff must be a licensed MD, NP, or PA in Nevada or Arizona. OAHS staff may also include RNs, MAs, and other medical staff.	A. Copy of most recent license
2. Service Delivery	
Initial Intake Visit 2.1 through 2.3 below describe the minimum requirements for the initial intake visit of a new patient in this service category.	
2.1. Health History Outpatient Ambulatory Health Service providers must conduct a health history assessment, which includes: • History of diagnosis, including date and believed route of transmission • Baseline body weight, measured for normal weight and height, and vital signs • Full medical history • Contact information from referring or recent care providers • Current medications and changes in regimen • The status of vaccinations, including dates of Pneumovax, Hepatitis A & B, varicella zoster (shingles), HPV, influenza and TDAP (tetanus, diphtheria, and pertussis) • Known allergies • Current and past alcohol, tobacco, and substance use • Clients born female should have detailed reproductive history including history of menses, contraceptive methods, pregnancy and childbirth, and pap smear results. Treatment for pregnant women should follow the guidelines for treating non-pregnant adults, as well as for prevention of perinatal transmission. The women's health status should be prioritized. • Laboratory data, including: o CD4 and HIV viral load o Genotype/phenotype (if indicated) o An interferon gamma release assay (such as Quantiferon TB gold), or PPD if an interferon gamma release assay is not possible for financial or logistical reasons. If the test is positive, a chest x-ray is required. ▪ If the x-ray is negative for active TB, latent therapy must be given.	2.1. Documentation in client record health history

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If the patient misses the appointment for the assay, the appropriate follow-up activity should be performed and documented.

Hepatitis A, B, and C screening
CBC with platelets
Comprehensive metabolic panel
Complete lipid panel (cholesterol and triglycerides)
STD screening for syphilis, gonorrhea and Chlamydia
Toxoplasmosis screening

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2.2. Anti-retroviral Therapy (ART)
ART is now recommended for all patients living with HIV. Viral load (VL) and CD4 count should be measured regularly. See the table below for recommended testing intervals:
<table>
<tr><th></th><th></th><th>Diagnosis</th><th>every 3 - 6 mo</th><th>every 12 mo</th></tr>
<tr><td rowspan="2">Any time</td><td>VL</td><td>X</td><td>X</td><td></td></tr>
<tr><td>CD4</td><td>X</td><td>X</td><td></td></tr>
<tr><td rowspan="2">>2 years ART</td><td>VL</td><td></td><td>X</td><td></td></tr>
<tr><td>CD4</td><td></td><td>X</td><td></td></tr>
<tr><td rowspan="2">>2 years ART
VL suppressed
CD4 300-500 (consistently)</td><td>VL</td><td></td><td></td><td>X</td></tr>
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VL suppressed
CD4>500 (consistently)</td><td>VL</td><td></td><td></td><td>X</td></tr>
<tr><td>CD4</td><td></td><td></td><td>opt</td></tr>
</table>
NOTE: Flexibility in scheduling may be allowed, depending on patient’s health status

A screening of any barriers that may affect compliance or adherence to medications and treatment must be performed (e.g., lack of housing, mental illnesses, etc.) at intake, as well as at follow-up visits.
Once the appropriate treatment is decided by the medical provider and patient, that treatment or therapy should be initiated using the most recent guidelines found on the Department of Health and Human Services (DHHS) web site: http://aidsinfo.nih.gov.
There must be documentation in the patient medical chart of discussions regarding medication(s) side effects, dosing schedule and related adherence issues by the time treatment is initiated.

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<td>2.2. Documentation in client record of ART treatment plan</td>
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<td>2.3. Mental Health and Substance Abuse
Providers must screen all new clients using a standardized mental health screening tool.</td>
<td>2.3. Documentation in client record of mental health and substance</td>
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• Referrals to mental health or substance abuse providers must be made promptly using a "warm hand-off."	abuse screening
Follow Up Visits Follow up visits are recommended every three to four months for patients on a stable antiviral regimen. For some patients doing well for long periods of time with long-standing undetectable viral load, the follow up can occur every six months. All patients should have at least two visits per year.	
2.4. Status and Updates Follow up visits should always record and address: (1) temperature, vital signs, and weight and (2) problem lists and updates.	2.4. Documentation in client record of status and updates
2.5. Treatment Plan Adherence and Update Adherence with the treatment plan should be assessed and reinforced at each visit, with changes made to the treatment plan as needed. These should be determined by the provider and client together.	2.5. Documentation in client record of treatment adherence assessment and/or update
2.6. Resistance Testing Resistance testing should be performed (if practical) for all clients. If not performed on all clients, resistance testing should be performed when viral failure to HAART has been demonstrated and/or when viral load suppression is not as expected after initiation of therapy.	2.6. Documentation in client record of resistance testing (if medically indicated)
2.7. Prophylaxis Prophylaxis for opportunistic infections should be offered to each client at the appropriate CD4 count. Refer to DHHS guidelines for prophylaxis for opportunistic infections. Documentation of current therapies should be maintained on all patients receiving prophylaxis.	2.7. Documentation in client record of prophylaxis (if medically indicated)
2.8. Laboratory Testing At least once per year, all clients should receive the following: • STDs: Syphilis serology, and screening for gonorrhea or Chlamydia for persons who may have been at risk for any of those infections • Hepatitis C screening for at-risk patients • Women should have a pap smear documented	2.8. Documentation in client record of annual laboratory testing
2.9. Education At least once per year, all clients should receive primary health care education, provided in language and at a literacy level appropriate to the client. Primary health care education must be documented in the client chart, and include the following components: • Prognosis/progression of HIV • How HIV is transmitted, and what client behaviors put others at risk for transmission of HIV	2.9. Documentation in client record of annual primary care education

(prevention for positives) • How to interpret lab results • Indications for treatment, goals for treatment, general information regarding side effects of treatment, treatment options, insurance/payment options, and availability of medication adherence support programs • Smoking cessation, and the interactions between smoking and HIV • Nutrition information • Oral health information • Substance abuse resources • Support groups and other psychosocial support services available	
Preconception Care for HIV Infected Women of Child Bearing Age Preconception care shall be provided for HIV infected women of child bearing age and should include preconception counseling. At a minimum, the preconception counseling should include: • Use of appropriate contraceptive method to prevent unintended pregnancy • Safe sexual practices • Elimination of illicit drugs and smoking • Education and counseling on risk factors for perinatal HIV transmission and prevention and potential effects of HIV and treatment on pregnancy and outcomes. • Available reproductive options	
Obstetric Care for HIV Infected Pregnant Women Obstetric care for HIV infected pregnant women shall be provided by board certified obstetrician experienced in the management of high-risk pregnancy and has at least two years experience in the care of HIV infected pregnant women. Antiretroviral therapy during ante partum, perinatal, and postpartum should be based on current DHHS guidelines.	
HIV Exposed and HIV Infected Infants, Children, and Adolescents Treatment of HIV infected infants, children, and adolescents should be managed by a specialist in pediatric and adolescent HIV infection. Where it is not possible, primary care providers must consult with such specialists. Providers must utilize current DHHS guidelines for the use of antiretroviral agents in pediatric HIV infection.	
3. Program Data and Reporting	
A. Outpatient/Ambulatory Health Services programs are required to collect the following data elements in the Las Vegas TGA CAREWare data system: • Year of birth • Ethnicity • Hispanic subgroup • Race • Asian subgroup • NHPI Subgroup • Gender	A. Documentation in Las Vegas TGA CAREWare

• Transgender subgroup • Sex at Birth • Health insurance • Housing status • Federal poverty level • HIV/AIDS status • Client risk factor • Vital enrollment status • HIV Diagnosis Year • HIV risk reduce screen/counseling • First outpatient/ambulatory health service visit • Outpatient/ambulatory health service visits • CD4 counts and dates • Viral Load Counts and Dates • Prescribed PCP prophylaxis • Prescribed HAART • Screened for TB since diagnosis • Screened for Hep B since diagnosis • Completed Hep B vaccine series • Screened for substance use • Screened for mental health • Pap smear • Pregnant • Date of first Positive HIV Test • Date of OAMC visit after first positive HIV test	
4. Policies and Procedures	
A. None at this time	A. N/A
5. Referral Policy	
A. All service providers must work in partnership with the client, their internal care coordination team and external providers (both Ryan White HIV/AIDS Program-funded and non-Ryan White-funded sites) to ensure appropriate and timely service referrals are made. For more information, see Las Vegas TGA *Referral Policy*.	A. For internal Ryan White Part A referrals: documentation in CAREWare. For external referrals: documentation in client record that referral was completed.