

RYAN WHITE PART B PEER REVIEW
Virginia Department of Health
Division of Disease Prevention
HIV Care Services
Chart Review

Outpatient/Ambulatory Medical Care (Health Services)

ID# _____

	YES	NO	NA	COMMENTS
A. Initial History and Physical Assessments: (if initial visit occurred within last 12 months from visit date)				
A.1. Initial medical history is documented within 30 days of client contact with provider?				
A.2. (Initial) Physical examination is documented within 30 days of client contact with the provider?				
A.3. Medication history which includes: a. drug allergies b. current medications c. drug/substance abuse				
A.4. Initial laboratory results or orders are documented as a component of the initial assessment.				
A.5. Oral Health assessment/referral is documented as a component of the initial assessment. This may be done by a primary care provider as long as it comments on any pathology and state of teeth.				
A.6. Psychosocial/Mental Health assessment and/or referral is documented as a component of the initial assessment.				
A.7. Nutritional assessment is documented as a component of the initial assessment. For clients with normal Body Mass Index (BMI) this may be an assessment of normal status; a more significant assessment should be done if BMI < 18,5 or there is significant interval unintended weight loss.				
A.8. Substance abuse assessment and/or referral is documented as a component of the initial assessment.				
B. Ongoing Assessments:				
B.1. History, every 6 months, or as needed				
B.2. Physical exam, every 6 months, or as needed				
B.3. Has client been seen at least twice in the past 12 months?				
B.3.a. If client has not been seen within last 6 months, is there documentation of client contact in the chart?				

- Includes updated information from Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. Available at <http://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-treatment-guidelines/0> (Last updated 4/8/2015)

B.3.b. If client has not been seen within the last 7 months is there documentation of referral to Case Manager or Patient Navigator services in the chart.				
B.4. Medical care plan is reassessed and updated every 6 months and a copy is offered to the client and documented in the chart.				
B.5. Laboratory testing, every 6 months, or as needed.				
B.6. Medication history which includes new: 1. Drug allergies 2. Current medications 3. Drug/substance abuse 4. Treatment adherence				
B.7. Oral health assessment, referral, and annual/routine dental care.				
B.8. Nutritional assessment/ or referral?				
B.9. Current (in last year) ophthalmology exam or referral if cluster of differentiation 4 (CD4) < 100 or medical history (hx) of Diabetes Mellitus (DM) or Hypertension (HTN).				
B.10. Is there documentation of current breast exam, where applicable in the client's record?				
B.11. Is there documentation of follow up from referrals in the client's record?				
C. Laboratory Reports/Other Tests Documentations (record lab dates on separate page)				
C.1. CD4, every 12 months, or as needed.				
C.2. Viral Load (Human Immunodeficiency Virus (HIV)/Ribonucleic Acid (RNA)), every 6 months, or as				
C.3. Complete blood count (CBC), every 12 months, or as needed.				
C.4. Chemistry Panel, every 6 months, or as needed				
C.5. Toxoplasmosis Antibody Titer at baseline if CD4<100.				
C.6 Resistance Genotyping/Phenotyping, as needed a) Genotypic resistance testing (baseline) b) Genotypic resistance testing (with treatment failure) c) Phenotypic resistance testing (known virologic failure; known complex drug resistance pattern(s))				
C.7. Lipid Panel (annually).				
C.8. Urinalysis (baseline & annually or if on TDF-tenofovir).				
C.9. Liver/Hepatic Panel (baseline; Annually unless co-infected with Hepatitis and then every 6 months or as needed.				

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C.10. Glucose (if not in Chem Panel; baseline & annually).				
C.10.a. Hemoglobin A1C every 6 months or as needed is diabetic.				
C.11. Hepatitis A serology at baseline C.11a. If negative, patient referred for immunization.				
C.12. Hepatitis B serology at baseline and as needed ongoing risk factor behavior. C.12.a. If negative patient referred for Immunization.				
C.13. Hepatitis C serology at baseline and as needed ongoing risk factor behavior. C.13.a. If positive, patient evaluated and /or referred for treatment.				
C.14. Sexually Transmitted Disease (STD) risk assessment evaluated at each visit (e.g. Syphilis, Gonorrhea, Chlamydia). C.14a. Asked about STD symptoms at each visit.				
C.15. Venereal Disease Research Laboratory Test (VDRL)/Rapid Plasma Reagin (RPR) initially and every 12 months with reports documented in chart on the record where applicable?				
C.16 Tuberculosis (TB) risk factors reviewed annually and as needed. C.16.a. TB testing Purified Protein Derivative (PPD) or interferon-based testing at initial presentation, repeated if baseline CD4+ was < 200 but has risen to > 200, and as needed based on risk factor review.				
C.17. Pap Smear, twice in first year and then annually thereafter -Are dates and results in the record?				
C.18. Mammogram annually > 50 years with dates and results in the record?				
C.19. Chest x-ray at baseline for patients with positive TB testing or as needed for underlying lung disease - dates and results in the record?				
C.20. Special Studies-other testing based on individual needs. Dates and results in the record (as applicable)				
C.21. Pre-Conceptual discussion and counseling for all women of childbearing age at baseline and routinely thereafter.				
D. Medications:				
D. 1. Are all current medications documented in the client's record?				
D. 2. Is medication adherence assessment with documentation done at each visit?				

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D. 3. Are medication side effects assessed and documented?				
D. 4. Does the client have a documented Acquired Immune Deficiency Syndrome (AIDS) diagnosis?				
D. 5. Has Highly Active Antiretroviral Therapy (HAART) been offered to the client, when				
D. 6. Is the client currently on Highly Active Antiretroviral Therapy (HAART)?				
D. 7. Is HAART consistent with current Public Health Services (PHS) Guidelines?				
D. 8. Is the client on Pneumocystis Jiroveci Pneumonia (PJP) prophylaxis if CD4<200?				
D. 9. Is the client on Toxoplasmosis Prophylaxis if CD4<100?				
D. 10. Is the client on Mycobacterium Avium Complex (MAC) Prophylaxis if CD4<50?				
E. Documentation:				
E. 1. Is an appropriate out-come based medical plan of treatment developed with the client and present in the client's record.				
E.1.a. Is there documentation that the client reviewed the plan and/or was offered a copy of the plan.				
E. 2. Is client education documented in the client's record?				
E. 3. Are progress notes present, current, legible, signed and dated in the client's record?				
E. 4. Is there documentation of a Prevention/Risk factor reduction/ Counseling message at each visit?				
F. Immunizations: (Is documentation present for)				
F. 1. Influenza (annually)				
F. 2. Pneumovax/Prevnar				
F. 3. Hepatitis A series- if serology is negative- is series completed.				
F. 4. Hepatitis B series -if serology is negative –is series completed?				
F. 5. Tetanus/Diphtheria (or Tdap x 1) (every/ ten years).				
F. 6. Others				
G. Third Party: (If third party payer)				
G.1. Is there adequate documentation of care provision in the client's record?				

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G.2. Are there an initial history, physical, and laboratory reports in the client's record?				
G.3. Do all progress notes reflect health status, response to treatment and services provided to client?				
G.4. Are there current laboratory reports in the client's record?				
G.5. Are there current medication records, AIDS Drug Assistance Program (ADAP) and non-ADAP (name of drug, dosage, time) in the client's record?				
G.6. Is appropriate referral and follow-up documented in the client's record?				
G.7. Is there documentation in the client's record that current standards of care for the human immunodeficiency virus (HIV)/AIDS client are practiced? If not, comment.				
For Qualifications, Training and Supervision; see Universal Administrative module.				

Reviewer: _____

Date: _____