

Outpatient/Ambulatory Medical Care (Health Services)

Definition: The provision of professional, diagnostic and therapeutic services rendered by those licensed in the Commonwealth of Virginia, who are a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary Medical Care* for the treatment of Human Immunodeficiency Virus (HIV) infection includes the provision of care that is consistent with Public Health Service guidelines. Such care must include access to antiretrovirals and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. Note: Early Intervention Services provided by Ryan White Part C and Part D Programs should be included here under Outpatient/Ambulatory medical care. (Health Resources and Services Administration (HRSA) definition)

Objectives for Service:

- Provide and coordinate high quality care for the needs of clients with HIV infection, consistent with current established clinical practice standards and current Public Health Services (PHS) guidelines.
- Assess and respond appropriately to the physical, psychosocial, cognitive, and therapeutic needs of clients.
- Appropriately involve the client and client's caregivers (with client consent), in supporting client's well-being through outreach, provision of information, and inclusion in care planning.
- Comply with recommended infectious disease protocols for outpatient care.
- Coordinate care with other service providers/service systems to ensure the client reach's his/her optimal level of health.
- Provide appropriate referrals as needed for assessment and treatment.

All service provision will comply with the United States Public Health Services medical standards of care and the Commonwealth of Virginia Department of Health standards for HIV infected persons, including the following:

STANDARD	MEASURE
Service Standards:	
The client's eligibility for Ryan White Part B services is determined or is in process of determination before services are initiated.	Documentation of the client's eligibility or that the eligibility process has been initiated and is present in the client's record.
Medical record reflects compliance with current USPHS (United States Public Health Services) medical standards of care and Virginia Department of Health (VDH) standards for HIV-infected persons.	Documented client care is in compliance with USPHS and VDH standards.
Assessment:	
A complete initial medical history including drug allergies, current medications and drug/substance abuse along with the physical assessment is conducted within 30 calendar days of client contact with provider.	Documentation of the initial medical history and physical assessment is present in the client's record, signed and dated.
An oral exam is part of the initial physical examination.	Documentation of the oral exam is present in the client's record, signed and dated. (An oral exam should include assessment of pathology as well as general assessment of dental status)
A psychosocial/mental health history is part of the initial medical assessment.	Documentation of the psychosocial/mental health is present in the client's record, signed and dated
A nutritional assessment is part of the initial medical assessment.	Documentation of the nutritional assessment and will be recorded in the client's record and signed and dated.
A medication history which includes drug allergies, current medications and drug/substance abuse is part of the medical assessment.	Documentation of the medical history for follow up visits is present in the client's record, signed and dated
Treatment Plan:	
A medical treatment plan is developed in collaboration with the client. The client is offered a copy of the medical plan.	Documentation of the medical care plan/education plan is present in the client's record, signed and dated. Documentation that a copy of the medical plan was offered to the client is present in the client's record.
Medical care plan must be reassessed every 6 months or when conditions or client needs arise that must be addressed	Documentation of the medical care plan/education plan reassessment every 6 months is present in the client's record. Documentation that a copy of reassessment was

	offered to the client is present in the client's record.
Clients who do not present for follow up care within 6 months should be referred to case management or patient navigator services in order to re-engage them in care.	Documentation of attempt at client contact if last visit was > 6 months is present in the client's record, signed and dated. Referral to Case Management or Patient Navigation services documented in the client's record, signed and dated.
Future or Continued Services:	
Provider adheres to current standards for prevention of opportunistic infections in HIV infected persons in compliance with USPHS standards.	Documentation verifies that appropriate prophylaxis was offered to client in compliance with USPHS standards and is present in the client's record, signed and dated.
Client is offered antiretroviral therapy, if clinically indicated in accordance with USPHS standards.	Documentation of the prescribed antiretroviral therapy (at minimum, 3-drug therapy) is present in the client's record, signed and dated by prescriber. OR Documentation explaining non-compliance with USPHS standards must be present in the client's record, signed and dated. OR Documentation if client refuses antiretroviral therapy is present in the client's record, signed and dated.
All medication and treatment records are current and complete.	Documentation of all current treatments and medications (with names of drugs, doses, timing, and methods of administration) is signed and dated within last 6 months (for antiretroviral therapy) or last 12 months (for Opportunistic Infection (OI) treatment) and present in the client's record.
All laboratory reports are current and complete.	Documentation that all laboratory reports have been reviewed by dating and signing/ initialing the results is present in the client's record.
Age appropriate health prevention/maintenance (HIV and other disease risk-reduction) measures are present on the client's record, e.g. mammograms, Prostate-Specific Antigen (PSA)/rectal exams, nutrition counseling.	Documentation of health prevention/maintenance measures and/or dates of referrals for these and appropriate test results is present in the client's record, signed and dated.
Age appropriate vaccination needs and documentation is present on the clients record.	Documentation of status for Hepatitis A, Hepatitis B, and Hepatitis C is present in the client's record, signed and dated. For clients who are not positive, referral for appropriate

	<p>vaccination and documentation of vaccination should be present on the client's record, signed and dated.</p> <p>Other vaccines should be administered as appropriate including: Annual Flu; Pneumococcal vaccination (Pneumovax23); Diphtheria, Tetanus, and Pertussis (dTdap); and others and should be documented in the record, signed and dated.</p>
All referrals and follow-up of each referral is documented.	Documentation of each referral with follow up is present in the client's record, signed and dated.
A HIV prevention message is provided at each visit.	Documentation of the HIV prevention message provided is present in the client's record, signed and dated.
Records are current, with legible signatures, dates, and progress notes. Provider should conduct periodic, random chart reviews for oversight	Documentation is current, up-to-date, with legible signatures, dates, and progress notes.
Medication Adherence is discussed at each client encounter.	Documentation of medication adherence discussion at each client encounter is present in the client's record, signed and dated.
Third Party Payer:	
When the agency is a third-party provider, the subcontractor maintains a client record to provide adequate documentation on the record for accountability of primary medical care provided by payee.	<p>At a minimum, payer's record must contain a statement(s) of:</p> <ol style="list-style-type: none"> 1. Medical history, physical examination, laboratory reports, medications, treatments and plan of care. 2. Interim progress notes, laboratory reports. 3. Referrals and follow-ups 4. All reports must be signed and dated.
Qualifications:	
All providers of outpatient/ambulatory medical care will hold current licensure in the Commonwealth of Virginia	<p>Copies of current licenses are maintained in the personnel files and are available for review. It is also available electronically at the Virginia Department of Health Professions website:</p> <p>https://www.dhp.virginia.gov/</p>
Annual Training:	
Continuing education of 10 hours of HIV/AIDS	Documentation of annual continuing education is available for review by the peer reviewers.