

RYAN WHITE PART B PEER REVIEW 2009-2010
Virginia Department of Health
Division of Disease Prevention
HIV Care Services
Chart Review

Outpatient/Ambulatory Medical Care (Health Services)

ID#

	YES	NO	NA	COMMENTS
1. Initial History and Physical Assessments:				
Admission History on the record				
Admission (Initial) Physical Examination on the record?				
Medication history which includes: a. drug allergies b. current medications c. drug/substance abuse				
Admission Laboratory results are on the record				
Oral Health assessment/referral is documented				
Psychosocial/Mental Health assessment and/or referral is documented				
Nutritional assessment is documented				
Substance Abuse assessment and/or referral is documented				
2. Ongoing Assessments:				
History, q. 3-6 months, or p.r.n.				
Physical Exam, q. 3-6 months, or p.r.n.				
Has client been seen at least twice in the past 12 months? (** dates)				
Laboratory Testing, q. 3-6 months, or p.r.n				
Medication history which includes: d. drug allergies e. current medications f. drug/substance abuse g. Treatment adherence				
Oral health assessment, referral, and annual/routine dental care				
Nutritional assessment/ or referral				
Current ophthalmology exam or referral?				
Is there documentation of current breast exam where applicable in the client's record?				
Is there documentation of all referrals and follow-ups in the client's record?				

***Please add dates of services.

	YES	NO	NA	COMMENTS
3. Laboratory Reports/Other Tests Documentations of: (record lab dates on separate page)				
*CD4, q. 3-6 months, or p.r.n. (**dates)				
*Viral Load (HIV/RNA), q. 3 - 6 months, or p.r.n.				
* CBC, q. 3-6 months, or p.r.n.				
* Chemistry Panel, q. 3 - 6 months, or p.r.n.				
Toxoplasmosis Antibody Titer				
Resistance Genotyping /Phenotyping, p.r.n.				
Hepatitis A serology				
Hepatitis B serology				
Hepatitis C serology If positive, patient evaluated and /or referred for treatment				
STD risk factors evaluated at each visit (e.g. Syphilis, Gonorrhea, Chlamydia)				
VDRL/ RPR reports on the record where applicable?				
PPD/TB factors reviewed, dates and results on records (** dates)				
Pap Smear, q. 6 - 12 mo, or p.r.n. (if applicable) -Are dates and results on the record?				
Mammogram, age appropriate (if applicable) dates and results on the record				
Chest x-ray prn - dates and results on the record?				
PSA, age appropriate (if applicable) - dates and results on the record				
Special Studies-other testing based on individual needs. Dates and results on the record (as applicable)				
4. Medications:				
Are all current medications documented in the client's record?				
Is medication adherence assessment with documentation done at each visit?				
Are medication side effects assessed/documented?				
Does the client have a documented AIDS diagnosis?				
Has HAART been offered to the client, when applicable?				
Is the client currently on HAART?				
Is HAART consistent with current PHS Guidelines?				
Is the client on PCP prophylaxis if CD4<200?				
Is the client on Toxoplasmosis prophylaxis if CD4<100?				
Is the client on MAC prophylaxis if CD4<50?				

***Please add dates of services.

	YES	NO	NA	COMMENTS
5. Documentation:				
Is an appropriate out-come based medical plan of treatment developed with the client and present in the client's record? Is there documentation that the client was offered a copy of the plan?				
Is Client Education documented on the client's record?				
Are progress notes present, current, legible, signed and dated in the client's record?				
If flow sheets are used, is data current?				
Does the data adequately reflect the health status of the client?				
Is there documentation of a Prevention/Risk factor reduction/ Counseling message at each visit?				
6. Immunizations Is documentation present for:				
Influenza (annually)				
Pneumovax				
Hepatitis A series (if serology negative) Is series completed?				
Hepatitis B series (if serology negative) Is series completed?				
Tetanus/Diphtheria (or Tdap x 1) (every/ ten years)				
Others				
7. Third Party:				
If <u>third party payer</u>, Is adequate documentation for accountability of primary medical care provided by payee in the client's record?				
Is there an initial history, physical, and laboratory reports in the client's record?				
Do all progress notes reflect health status, response to treatment and services provided to client?				
Are there current laboratory reports in the client's record?				
Are there current medication records, ADAP and non-ADAP (name of drug, dosage, time) in the client's record?				

	YES	NO	NA	COMMENTS
Are appropriate referral and follow-up documented in the client's record?				
Is there documentation in the client's record that current standards of care for the HIV/AIDS client are practiced? If not, comment.				

In the table below, please note dates for all the following labs: CD4 count, Viral load, TB test and reading, Pap smear, pneumovax, influenza, Hep A series, Hep B series.

Labs – Type	Date

Reviewer_____

Provider staff interviewed_____

Date_____