Outpatient Ambulatory Health Services Standards

Description from Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02:
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.

Emergency room and non-HIV related urgent care visits are not allowable costs within the Outpatient/Ambulatory Health Services Category

Virginia Ryan White Part B Service Unit Definition:
One medical prescribing provider visit (virtual or in-person) per day per physician/group practice for an uninsured client (**and/or**) one individual lab test (e.g., a panel of five lab tests = five units) for uninsured clients.

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV (PWH), including the following:

1.0 Intake and Eligibility

As outlined in HRSA HIV/ AIDS bureau (HAB) Policy Clarification Notice (PCN) 21-02 Clarifications on Ryan White Program Client Eligibility Determinations and Recertification Requirements, people are eligible to receive RWHAP services when they meet each of the following factors:

1. **HIV Status:** A documented diagnosis of HIV. (Note: People who do not have an HIV diagnosis are eligible to receive certain services as outlined in HRSA HAB PCN 16-02

2. **Low- Income:** The RWHAP recipient defines low-income. Low-income may be determined based on percent of Federal Poverty Level (FPL), which can be measured in several ways (e.g., Modified Adjusted Gross Income, Adjusted Gross Income, Individual Annual Gross Income, and Household Annual Gross Income).

3. **Residency:** The RWHAP recipient defines its residency criteria, within its service area. Note: Immigration status is irrelevant for the purposes of eligibility for RWHAP services. RWHAP recipients or subrecipients should not share immigration status with immigration enforcement agencies.

Standard	Measure
Referral	
1.1) Documentation of self-referral or referral by a Part B provider for Outpatient Ambulatory Health Services (OAHS) prior to initiation of the service.	1.1) Appointment documented to attend OAHS is present in the client's record.
Eligibility	
1.2) The client's eligibility for Ryan White Part B services must be determined prior to providing the service. To be eligible for this service, clients must: a) Have an HIV diagnosis (one time only) b) Live in Virginia c) Have an individual or family income at or below 500% of the Federal Poverty Level (FPL) d) Be ineligible for other payer sources covered by Federal or State programs such as Medicare, Medicaid, all other forms of insurance or third party payers such as private and commercial	1.2) Documentation of the client's eligibility is present in the client's record that verifies: a) Client is diagnosed with HIV b) Client lives in Virginia c) Client meets income guidelines d) Client's Medicaid status verified (gap of services) • Ongoing CARS and complete Continuation Eligibility Assessment every 24 months • Client agrees to participate in insurance option that best meets their medical needs and for which the client is eligible.

insurance plans, and other payers that provide the service they are seeking. • Client Access Reviews (CARs) - refer to periodic checks of enrolled RWHAP B clients to identify any potential changes that may affect eligibility. • Provide continuation of eligibility every 24 months with proof of income, changes in insurance coverage, or any changes in residency • Client eligibility ensures the use of Part B services as the payer of last resort while vigorously pursuing other funding sources**.** Client must agree to participate in the insurance option that the client is eligible for and that best meets the client's medical needs regardless of preference. Submission of eligibility assessments should be through the Provide Enterprise® data system.	
Intake	
1.3) Complete eligibility screening and intake within 15 days of initial contact with client.	1.3) Documentation of intake, eligibility screening in client record signed and dated.
Client Access Reviews/Continuation of Eligibility	
1.4) Client Access Reviews (CARs) refer to periodic checks of enrolled RWHAP B clients to identify any potential changes that may affect eligibility and continuation of eligibility conducted every 24 months to continue to receive Ryan White services. There is no grace period.	1.4) Documentation of CARS and continuation of eligibility is present in the client's record.
2.0 Key Services Components and Activities	
Standard	**Measure**
Documentation	
2.1) Documentation in client record of all OAHS provided.	2.1) Documentation of OAHS is in client's record signed and dated.

2.2) When a third-party payer provides service, the sub-recipient must maintain a client record. At a minimum, the payer's record and the dental agencies record must contain: • Referral; • Initial assessment; • Individualized treatment plan, including treatment modality and frequency and quantity of treatments; • Documentation of all contacts & dates of service; • Reassessment of treatment plan to include monitoring and assessment of client progress; • Referrals and follow-ups; and • Discharge plan. Must sign and date all reports.	2.2) Documentation of provided services, signed and dated records, including referral in record.
Assessment/Service Plan/Provision of Services	
2.3) Perform a comprehensive initial medical history and physical examination within 30 days of client contact with provider. Additional dimensions of the comprehensive history and assessment include: • Oral health assessment • Psychosocial/Mental health assessment • Substance use screening and assessment • Nutritional assessment. • TB Risk Assessment and TB Test with performance of or referral for additional evaluation as indicated (i.e., chest x-ray if positive test for TB infection or if active TB symptoms are identified).	2.3) Documentation of comprehensive medical history and physical assessment in client's record signed and dated by provider. Document referral to the Local Health Department for individuals with presumptive active TB.
2.4) Complete initial Physical Examination within 30 days of client contact with the provider.	2.4) Documentation of initial physical assessment in client's record signed and dated by provider.
2.5) Medication history assessment which includes: a) Drug allergies	2.5) Documentation of medical history in client's record signed and dated by provider.

b) Current medications c) Drug/substance use	
2.6) Evaluate all persons with HIV for Latent Tuberculosis Infection (LTBI) at the time of HIV diagnosis, regardless of their epidemiological risk of TB exposure (AII). If the TB test is positive, refer for chest x-rays or other necessary follow up tests. Mycobacterium tuberculosis Infection and Disease | NIH (hiv.gov)	2.6) Documentation of review all labs/skin test in client's record.
2.7) Develop a medical treatment plan in collaboration with the client and offer the client a copy of the medical plan.	2.7) Documentation of the medical care plan in the client's record and a copy of the visit documentation which includes a care plan offered to patient. Include any TB-related treatment and follow-up in treatment plan.
2.8) If seen for a visit, medical care plan is updated every six months or more frequently, as needed.	2.8) Documentation in the client record that the medical care plan is updated at least every six months, if patient is seen for a visit, signed and dated by medical care provider
Follow Up Visits	
A.1) Provision of the following services in accordance with HHS HIV Treatment Guidelines as part of the treatment of HIV infection: • Diagnostic testing, including laboratory testing • Early intervention and risk assessment • Preventive care and screening • Physical examination • Medical history taking • Diagnosis, treatment, and management of physical and behavioral health conditions • Behavioral risk assessment, subsequent counseling and referral • Prescription and management of medication therapy • Access to antiretroviral therapies, including combination antiretroviral treatment, and prophylaxis and treatment of opportunistic infections • Treatment Adherence	A.1) Documentation of services in client's record signed and dated by provider.

• Education and counseling on health and prevention issues • Pediatric developmental assessment/Well-baby care • Referral to and provision of HIV-related specialty care related to HIV diagnosis. *Note:* Must provide care in outpatient setting, such as clinic, medical office or mobile van. Only allowable services can be provided. Specialty medical care relates to HIV infection and/or conditions arising from the use of HIV medications resulting in side effects.	
A.2) History, minimum q. 6 months, or p.r.n.	A.2) Documentation of services in client's record signed and dated by provider.
A.3) Physical Exam, minimum q. 6 months, or p.r.n.	A.3) Documentation of services in client's record signed and dated by provider.
A.4) Laboratory Testing, minimum q. 6 months, or p.r.n	A.5) Documentation of services in client's record signed and dated by provider.
A.5) Medication history reviewed at each visit which includes new: a) Drug allergies b) Current medications c) Drug/substance abuse d) Treatment adherence	A.6) Documentation of services in client's record signed and dated by provider.
A.6) Oral health assessment, referral, and/or annual/routine dental care to be completed	A.7) Documentation of Oral Health assessment, referral, and/or annual/routine services in client's record signed and dated by provider.
A.7) Nutritional assessment or referral to be completed	A.8) Documentation of services in client's record signed and dated by provider.
A.8) Current (in last year) ophthalmology exam or referral if CD4 < 100 or hx of DM or HTN to be completed	A.9) Documentation of services in client's record signed and dated by provider.
A.9) Breast exam to be completed, where applicable (females)	A.10) Documentation of current breast exam, where applicable in the client's record. (females)

A.10) Follow up from referrals documented	A.11) Check documentation of follow up from referrals in the client's record.
B.1) CD4, q. minimum 12 months, or p.r.n.	B.1) Documentation of services in client's record signed and dated by provider.
B.2) Viral Load (HIV/RNA), minimum q. 6 months, or p.r.n.	B.2) Documentation of services in client's record signed and dated by provider.
B.3) CBC, minimum q.12 months, or p.r.n.	B.3) Documentation of services in client's record signed and dated by provider.
B.4) Chemistry Panel, minimum q. 6 months, or p.r.n.	B.4) Documentation of services in client's record signed and dated by provider.
B.5) Toxoplasmosis Antibody Titer at baseline if CD4< 100.	B.5) Documentation of services in client's record signed and dated by provider.
B.6) Resistance Genotyping /Phenotyping, p.r.n. a) Genotypic resistance testing (baseline; treatment failure) b) Phenotypic resistance testing (known virologic failure; known complex drug resistance pattern(s)	B.6) Documentation of services in client's record signed and dated by provider.
B.7) Lipid Panel (annually)	B.7) Documentation of services in client's record signed and dated by provider.
B.8) Urinalysis (baseline & annually or if on TDF- tenofovir difumarate)	B.8) Documentation of services in client's record signed and dated by provider.
3.9) Liver/Hepatic Panel (baseline; minimum annually)	B.9) Documentation of services in client's record signed and dated by provider.
B.10) Glucose (if not in Chem Panel; baseline& annually); Hemoglobin A1C minimally annually or p.r.n.	B.10) Documentation of services in client's record signed and dated by provider.
B.11) Hepatitis A serology at baseline	B.11) Documentation of services in client's record signed and dated by provider.
If negative, patient referred for Immunization	Documentation of services in client's record signed and dated by provider.

B.12) Hepatitis B serology at baseline and p.r.n. ongoing risk factor behavior	B.12) Documentation of services in client's record signed and dated by provider.
If negative patient referred for Immunization	Documentation of services in client's record signed and dated by provider.
B.13) Hepatitis C serology at baseline and annually if negative and ongoing risk factor behavior	B.13) Documentation of services in client's record signed and dated by provider.
If positive, patient evaluated and /or referred	Documentation of services in client's record signed and dated by provider.
B.14) STD risk assessment evaluated at each visit (e.g. Syphilis, Gonorrhea, Chlamydia)	B.14) Documentation of services in client's record signed and dated by provider.
B.15) Asked about STD symptoms at each visit	B.15) Documentation of services in client's record signed and dated by provider.
B.16) VDRL, syphilis IgG as first test and then reflex to RPR and FTAbs q12 months with reports on the record where applicable.	B.16) Documentation of services in client's record signed and dated by provider.
B.17) TB risk factors reviewed annually and p.r.n,	B.17) Documentation of services in client's record signed and dated by provider.
B.18) TB testing (TST or interferon-based testing) at initial presentation, repeated if baseline CD4+ was < 200 but has risen to > 200, and p.r.n based on risk factor and symptom review?	B.18) Documentation of services in client's record signed and dated by provider.
B.19) **Women with HIV (WWH) Infection Aged <30 years:** WWH ages 21 to 29 years should have a Pap test at the time of initial diagnosis with HIV. The next Pap test should occur in 12 months (BII). If the results of three consecutive Pap tests are normal, follow-up Pap tests should be every 3 years (BII). Co-testing (Pap test and HPV test) is not recommended for WWH <30 years of age.	B.19) Documentation of services in client's record signed and dated by provider.
B.20) **Women with HIV Aged ≥30 years:** Cervical cancer screening in WWH should continue throughout a woman's lifetime (and not, as in the general population, end at 65 years of age). Either Pap testing only, or Pap	B.20) Documentation of services in client's record signed and dated by provider.

testing and HPV co-testing is acceptable for screening.	
B.21) Mammogram annually > 50 years with dates and results in the record?	B.21) Documentation of services in client's record signed and dated by provider.
B.22) Chest x-ray at baseline for patients with positive TB testing or prn for underlying lung disease – dates and results in the record, education about LTBI risk provided, and initiation or referral for LTBI treatment if indicated?	B.22) Documentation of services in client's record signed and dated by provider. Documentation of LTBI treatment regimen, initiation date and completion date.
B.23) Special Studies-other testing based on individual needs. Dates and results in the record (as applicable)	B.23) Documentation of services in client's record signed and dated by provider.
B.24) Pre-Conceptual Discussion and Counseling for all women of childbearing age at baseline and routinely thereafter.	B.24) Documentation of services in client's record signed and dated by provider.
C.1) Current medications documented in the client's record	C.1) Are all current medications documented in the client's record?
C.2) Medication adherence assessment done at each visit	C.2) Is medication adherence assessment with documentation done at each visit?
C.3) Medication side effects assessed and documented	C.3) Documentation of services in client's record signed and dated by provider.
C.4) When applicable, document clients AIDS diagnoses status	C.4) Does the client have a documented AIDS diagnosis?
C.5) Document if highly active antiretroviral therapy (HAART) has been offered to the client	C.5) Has HAART been offered to the client, when applicable?
C.6) Document if the client currently on HAART	C.6) Documentation of services in client's record signed and dated by provider.
C.7) Ensure HAART is consistent with current PHS Guidelines?	C.7) Is HAART consistent with current PHS Guidelines?
C.8) Client on PCP prophylaxis if CD4<200	C.8) Documentation in client's record signed and dated by provider.
C.9) Client on Toxoplasmosis prophylaxis if CD4<100	C.9) Documentation in client's record signed and dated by provider.

C.10) People with HIV who are not receiving ART or who remain viremic on ART but have no current options for a fully suppressive ART regimen should receive chemoprophylaxis against disseminated Mycobacterium avium complex (MAC) disease if they have CD4 counts <50cells/mm3**(AI)**. *Primary prophylaxis against disseminated MAC disease **is not recommended** for adults and adolescents with HIV who immediately initiate ART **(AII)**.	C.10) Documentation in client's record signed and dated by provider.
D.1) An appropriate outcome based medical plan of treatment developed with the client	D.1) Documentation of an appropriate outcome based medical plan of treatment developed with the client and present in the client's record.
D.2) Client Education documented in the client's record?	D.2) Documentation of services in client's record signed and dated by provider.
D.3) Progress notes present, current, legible, signed and dated in the client's record.	D.3) Are progress notes present, current, legible, signed and dated in the client's record?
D.4) Prevention and Risk factor reduction/ Counseling message provided at each visit?	D.4) Documentation of Prevention and Risk factor reduction/ Counseling message at each visit in client's record signed and dated by provider.
E.1) Influenza (annually)	E.1) Documentation of services in client's record signed and dated by provider.
E.2) Pneumovax 23	E.2) Documentation of services in client's record signed and dated by provider.
E.3) Prevnar 13	E.3) Documentation of services in client's record signed and dated by provider.
E.4) Hepatitis A series- if serology is negative- is series completed?	E.4) Documentation of services in client's record signed and dated by provider.
E.5) Hepatitis B series –if serology is negative –is series completed?	E.5) Documentation of services in client's record signed and dated by provider.

E.6) Tetanus/Diphtheria (or Tdap x 1) (every/ ten years)	E.6) Documentation of services in client's record signed and dated by provider.
E.7) Others COVID-19 vaccinations based on current CDC guidelines HPV and meningococcal vaccinations based on current CDC guidelines	E.7) Documentation of services in client's record signed and dated by provider.
F.1) Is there adequate documentation of care provision in the client's record?	F.1) Documentation of services in client's record signed and dated by provider.
F.2) Are there an initial history, physical, and laboratory reports in the client's record?	F.2) Documentation of services in client's record signed and dated by provider.
F.3) Are all progress notes reflecting health status, response to treatment, and services provided to client?	F.3) Documentation of services in client's record signed and dated by provider.
F.4) Are there current laboratory reports in the client's record?	F.4) Documentation of services in client's record signed and dated by provider.
F.5) Are there current medication records, ADAP and non-ADAP (name of drug, dosage, time) in the client's record?	F.5) Documentation of services in client's record signed and dated by provider.
F.6) Is appropriate referral and follow-up documented in the client's record?	F.6) Documentation of services in client's record signed and dated by provider.
F.7) Is there documentation in the client's record that current standards of care for the HIV/AIDS client are practiced? If not, comment.	F.7) Documentation of services in client's record signed and dated by provider.
F.8) Provide laboratory tests integral to the treatment of HIV infection and related complications. Tests must be: a) Ordered by a certified, licensed provider b) Consistent with medical and laboratory standards c) Approved by the Food and Drug Administration (FDA) and/or Certified under the Clinical Laboratory Improvement Amendments (CLIA) Program.	F.8) Documentation of laboratory tests performed in client's record, signed and dated.

F.9) Refer clients not following up with Outpatient Ambulatory Health Services for six (6) months to case management or patient navigator services for re-engagement in care.	F.9) Documentation of attempts to contact client and referrals in the client's record signed and dated.
F.10) Refer client to HIV specialty care and/or other services as appropriate, e.g. mental health, substance abuse treatment.	F.10) Documentation of referrals made and status of outcome in client's record.
Transition and Discharge	
2.10) Client discharged when outpatient ambulatory health services are no longer needed, goals have been met, upon death or due to safety issues. (*see 2.11*) <u>Prior to discharge</u>: Conduct discussion with client over reasons for discharge and options for other service provisions. Whenever possible, discussion should occur face-to-face. If not possible, provider should attempt to talk with client via phone. If verbal contact is not possible, a certified letter* must be sent to client's last known address. Must return letter to provider if the client is not present to sign. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff, that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.* <u>Documentation:</u> Client's record must include: a) Date services start b) Special client needs c) Services needed/actions taken, if applicable d) Date of discharge e) Reason(s) for discharge f) Referrals made at time of discharge, if applicable. <u>Transfer:</u> If client transfers to another location, agency or service provider, transferring agency will provide discharge summary and other requested records within 5 business days of	2.10) Documentation of discharge plan and summary in client's record with clear rationale for discharge within 30 days of discharge, including certified letter*, if applicable. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff, that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.* Discharge summary and other records send with the patient

request. If client moves to another area, transferring agency will make referral for needed services in the new location. Unable to Locate: If client cannot be located, agency will make and document a minimum of three follow-up attempts on three separate dates (by phone or in person) over a three-month period after first attempt. The three attempts should start no later than three months prior to the due date. A certified letter* must be mailed to the client's last known mailing address within five business days after the last attempt to notify the client. The letter will state case closure within 30 days from the date on the letter if no appointment is schedule with the provider. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff, that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.* Withdrawal from Service: If client reports no longer needing services or decides to no longer participate in the Service Plan, client may withdraw from services. Because clients may withdraw for a variety of reasons it may be helpful to conduct an exit interview to ensure understanding reasons for withdrawal, or if client still needs services identify factors interfering with the client's ability to fully participate. If other issues are identified that cannot be managed by the agency clients should be referred to appropriate agencies. Administrative Discharge: Discharge clients who engage in behavior that abuses the safety or violates the confidentiality of others. Prior to discharging a client for this reason, agency leadership according to that agency's policies must review the case. Provide clients discharged for administrative reasons written notification of and reason for the discharge and	Document attempts made

notify of possible alternative resources. A certified letter* that notes the reason for discharge and includes alternative resources must be mailed to the client's last known mailing address within five business days after the date of discharge, and a copy must be filed in the client's chart. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff, that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.*	
Case Closure	
2.11) Case will be closed if client: a) Has met the service goals; b) Decides to transfer to another agency; c) Needs are more appropriately addressed in other programs; d) Moves out of state; e) Fails to provide updated documentation of eligibility status thus, no longer eligible for services; f) Fails to maintain contact with the insurance assistance staff for a period of three months despite three (3) documented attempts to contact client; g) Can no longer be located; h) Withdraws from or refuses funded services, reports that services are no longer needed, or no longer participates in the individual service plan; i) Exhibits pattern of abuse as defined by agency's policy. j) Becomes housed in an "institutional" program anticipated to last for a minimum of 30 days, such as a nursing home, prison or inpatient program; or	2.11) Documentation of case closure in client's record with clear rationale for closure.

k) Is deceased.	
3.0 Client Rights and Responsibilities	
Standard	**Measure**
3.1) Services are available and accessible to any individual who meets program eligibility requirements. Each provider shall assist clients with conducting Ryan White Part B eligibility, regardless of whether they receive other Part B services at your agency. All providers shall comply with all applicable federal, state, and local anti-discrimination laws and regulations, including but not limited to the Americans with Disabilities Act. All providers shall adopt a non-discrimination policy prohibiting the refusal of rendering services based on the fact or perception of race, color, creed, religion, national origin, ancestry, age, sex, sexual orientation, gender identity, domestic partner status, marital status, height, weight, disability, or HIV/AIDS diagnosis. Each provider shall make available to clients a process for requesting interpretation services, including American Sign Language.	3.1) Written eligibility requirements and non-discrimination policy on file.
3.2) Each agency should have a Client's Rights and Responsibilities policy, which requires each client to sign & date a form indicating they have been offered: a) explanation of the policy, and b) copy of *'Client's Rights and Responsibilities* and to communicate client's understanding of the policy.	3.2) Written policy on file.
3.3) Explanation of *Client's Rights and Responsibilities* is provided to each client. Client rights include:	3.3) Current *Client's Rights and Responsibilities* form signed and dated by client and located in client's record. If client unable to sign, progress note should include

• Be treated with respect, dignity, consideration, and compassion; • Receive services free of discrimination; • Be informed about services and options available. • Participate in creating a plan of services; • Reach an agreement about the frequency of contact the client will have either in person or over the phone. • File a grievance about services received or denied; • Not be subjected to physical, sexual, verbal and/or emotional abuse or threats; • Voluntary withdraw from the program; • Have all records be treated confidentially; Have information released only when: • A written release of information is signed; • A medical emergency exists; • There is an immediate danger to the client or others; • There is possible child or elder abuse; or • Ordered by a court of law. Client responsibilities include: • Treat other clients and staff with respect and courtesy; • Protect the confidentiality of other clients; • Participate in creating in a plan of service; • Let the agency know any concerns or changes in needs; • Make and keep appointments, or when possible to phone to cancel or change an appointment time; • Stay in contact with the agency by informing the agency of change in address and phone number, as well as responding to phone calls and mail and • Not subjecting the agency's staff to physical, sexual, verbal and/or emotional abuse or threats.	documentation the client has received a copy of the rights and responsibilities.

4.0 Grievance Process	
Standard	**Measure**
4.1) Grievance policy requires each client to sign & date indicating they have been offered: a) explanation of the policy, and b) copy of *Grievance Procedure,* and c) communication that client understands the policy. Policy shall describe the process for resolving client grievances, including the identification of whom to contact and applicable timelines. Policy shall be available in languages and formats (e.g. for persons with disabilities) appropriate to populations served.	4.1) Written grievance procedure on file, available in languages and formats appropriate to populations served.
4.2) Provide explanation of *Grievance Procedure* to each client. Clients may file a grievance if denied their request for services, if they have any complaint, or concern about the services received.	4.2) Current *Grievance Procedure* form signed and dated by client and located in client's record. If client unable to sign, progress note should include documentation the client has received a copy of the grievance procedure.
4.3) Grievance process shall be fair and expeditious for resolution of client grievances.	4.3) Documentation of client grievances, status, and resolution.
4.4) Review the grievance policy yearly with client signature.	4.2) Current *Grievance Procedure* form signed and dated by client and located in client's record. If client unable to sign, progress note should include documentation the client has received a copy of the grievance procedure.
5.0 Personnel Qualifications (including licensure)	
Standard	**Measure**
5.1) All physicians, physician's assistants, clinical nurse specialists and nurse practitioners will have appropriate and valid licensure and certification by the Commonwealth of Virginia.	5.1) Copy of current licensure/certification in personnel file.

5.2) All providers must complete their required continuing education in HIV/AIDS treatment or care annually.	5.2) Documentation of agency process to track completed trainings.
6.0 Cultural and Linguistic Competency	
Standard	**Measure**
6.1) Health services are culturally and linguistically competent, client-guided and community based. At a minimum, provider's documentation should include: a) Experience with providing services to the diverse ethnic, linguistic, sexual or cultural populations targeted; b) Capacity of staff, including volunteers and Board, to design, provide and evaluate culturally and linguistically appropriate services; c) List of cultural competency trainings completed by staff.	6.1) Documentation of cultural and linguistic competence as reported in annual Cultural and Linguistic Competency Report.
6.2) Easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area shall be available.	6.2) Culturally and linguistically appropriate materials and signage accessible.
7.0 Privacy and Confidentiality (including securing records)	
Standard	**Measure**
7.1) Client confidentiality policy exists which include: a) Release of information requirements, and b) Health Insurance Portability and Accountability Act compliance were applicable.	7.1) Written Client confidentiality policy on file at provider agency.
7.2) Client's consent for release of information is determined.	7.2) Current *Release of Information Form* signed and dated by client and provider representative and located in client's record. Each release form indicates who may receive the client's information and has an expiration of not more than 12 months from date of signature.

7.3) Store each client's file in a secure location with electronic client records protected from unauthorized use.	7.3) Files stored in locked file or cabinet with access limited to appropriate personnel. Electronic files are secure with password protected and access limited to appropriate personnel.
7.4) Annual submission of *Verification of Receipt of Assurance of Key Requirements* document by all staff that handle client identifying information.	7.4) Documentation of signed *Verification of Receipt of Assurance of Key Requirement* forms.
8.0 Quality Management	
Standard	**Measure**
8.1) Measure and report client health outcomes using Outpatient Ambulatory Health Services measures approved by VDH.	8.1) Performance measurement data on the following indicators: • Percentage of people with HIV and receiving Outpatient Ambulatory Health Services, regardless of age, with at least two care markers in a 12-month period that are at least 3 months apart. (Care marker defined as evidence of a HIV medical care visit date, a CD4 count and test date, a viral load value and test date, and/or an antiretroviral medication prescription and date). • Percentage of people enrolled in RW Part B-funded Program with HIV and receiving Outpatient Ambulatory Health Services, regardless of age, who will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

References

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