DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

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MURIEL BOWSER, MAYOR

HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA)

OUTPATIENT/AMBULATORY HEALTH SERVICES (OAHS)

Introduction

The purpose of these service standards is to outline the elements and expectations all Ryan White service providers are to follow when implementing a specific service category. Service Standards define the minimal acceptable levels of quality in service delivery and to ensure that a uniformity of service exists in the Washington, DC Eligible Metropolitan Area (EMA) such that customers of this service category receive the same quality of service regardless of where or by whom the service is provided. Service Standards are essential in defining and ensuring that consistent quality care is offered to all customers and will be used as contract requirements, in program monitoring, and in quality management.

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Outpatient /Ambulatory Health Services

Outpatient/ambulatory health services includes the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, or nurse practitioner in an outpatient setting. The provision of HIV care and treatment services consistent with the most recent US Department of Health and Human Services guidelines and provided in the context of an ongoing relationship with a personal provider who has comprehensive knowledge of the patient's medical conditions; facilitates linkages to and provides information to sub-specialists or other services involved in the care of the patient and actively participates in coordinating care with other qualified professionals.

- To ensure the quality of care, primary care and HIV care should be delivered in the same place. If this cannot be done, the overall health care of patients with HIV infection must be carefully managed to maximize health outcomes. Given the improved survival among persons living with HIV infection, and studies that suggest those living with HIV are at higher risk for developing comorbid health problems, the provider must monitor people living with HIV for all relevant age and gender specific health problems and referred for appropriate testing and/or treatment as needed.

- The standards do not dictate whether People who have HIV should receive their care from a specialist or a generalist. The emphasis is the importance of the primary care needs of persons with HIV infection and that patients have better outcomes when they receive their care from experienced HIV care providers. The HIV Medical Association and the American Academy of HIV Medicine provide guidelines for what is considered an experienced HIV care provider.

- The medical home model of care is recommended, in which a multidisciplinary team of health providers with specific roles coordinates a comprehensive, personalized, patient-centered approach. It is the responsibility of the provider to implement strategies to retain patients in care, re-engage patients who have been out of care and to ensure that all efforts translate into improved health outcomes for the patient.

SERVICE CATEGORY DEFINITION

Outpatient/Ambulatory Health Services (OAHS) provide diagnostic and therapeutic-related activities directly to a patient 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. Non-HIV related visits to urgent care facilities are not allowable costs within the Outpatient/Ambulatory Health Services Category. Emergency room visits are not allowable costs within the Outpatient/Ambulatory Health Services Category.

This document represents a synthesis of published standards and research, including:

- Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents, Department of Health and Human Services, 2019 (here)
- Medical Outpatient Services , Standards of Care, Los Angeles County Commission on HIV (here)
- Ambulatory/Outpatient Medical Care Contract Exhibit, Office of AIDS Programs and Policy (here)
- HIV Resources for Health Care Provider (here)
- Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (here)
- Guidelines for Implementing HIV/AIDS Medical Nutrition Therapy Protocols (here)
- Nutrition Intervention in the Care of Persons with Human Immunodeficiency Virus Infection – Position of the American Dietetic Association and Dietitians of Canada, Journal of the American Dietetic Association, 2010 (here)
- New York State Department of AIDS Institute: Clinical Guideline Program (here)
- Integrating HIV Care, Treatment and Prevention Services into primary care- A Toolkit for Health (here)

- Guidelines for the provision of HIV/AIDS medical care coordination services in Los Angeles County, 2016 (here)
- 90/90/90/50 Plan, Ending the HIV Epidemic in the District of Columbia by 2020 (here)
- 2017 -2021 District of Columbia Eligible Metropolitan Area – Integrated HIV/AIDS Prevention and Care Plan (here)
- DC-ADAP Program (here)
- District of Columbia HIV Medical case Management Guidelines (here)
- Guidelines for the use of Antiretroviral Agents in Adults and Adolescents living with HIV: Laboratory Testing: Drug- Resistance Testing: Panel Recommendations regarding Drug-Resistance Testing (here)
- Center for Disease Control and Prevention: Screening in clinical setting (here)
- HIV InSite, comprehensive up-to-date information on HIV/AIDS treatment and prevention from the university of California, San Francisco (here)
- Updated Guidelines for Antiretroviral Postexposure Prophylaxis After Sexual, Injection Drug Use, or Other Nonoccupational Exposure to HIV— United States, 2016 (here)
- Part B: AIDS Drug Assistance Program (here)
- Alternate Payment Models for Ryan White HIV/AIDS Program Funded Services: Strategies Used by Nine Grantees Prepared for the District of Columbia HIV/AIDS, Hepatitis, STD and TB Administration (here)
- Center for Disease Control and Prevention: State Laboratory Reporting Laws: Viral Load and CD4 Requirements (here)
- The Body at https://www.thebodypro.com/;
- HIV InSite at http://hivinsite.ucsf.edu/
- Johns Hopkins AIDS Service at https://www.hopkinsmedicine.org/health/conditions-and-diseases/hiv-and-aids
- Medline Plus – AIDS at https://medlineplus.gov/hivaidsandinfections.html
- DC Health/HAHSTA: Annual Epidemiology & Surveillance Report: Data through December 2019 (here)
- 2017 – 2021 Integrated HIV Prevention & Care Plan; Office of infectious Diseases Washington State Department of Health (here)
- Update to CDC's Treatment guidelines for Gonococcal Infection, 2020, Morbidity and Mortality Weekly Report (MMWR) 69(50): 1911-1916 (here)
- 2015 Sexually Transmitted Diseases Treatment Guidelines (here)
- NASTAD: Services Standards for Ryan White HIV/AIDS Program for Part B, 2018 (here)
- United States Preventive Services TASK FORCE, Recommendation for Breast Cancer (here)
- United States Preventive Services TASK FORCE:BRCA-Related Cancer Risk Assessment (here)
- Colon Cancer, USPSTF: Colorectal Cancer Screening 2016
- Cervical Cancer; USPSTF: Screening for Cervical Dysplasia and Cancer 2018;
- New York State Department of AIDS Institute : NYDOH screening for Cervical Cancer
- Anal dysplasia and Cancer; NYSDOH screening for Anal Dysplasia
- Lung Cancer: USPSTF Lung Cancer Screening

- District of Columbia Red Carpet program (here)
- Rapid ART Initiation for People diagnosed with HIV, 2020 (here)
- Center for Disease Control and Prevention: Treatment of LTBI and TB for persons with HIV (here)
- New York State Department of Health AIDS Institute: Clinical Guidelines Program: Cervical Screening for Dysplasia and Cancer (here)
- New York State Department of Health AIDS Institute: Clinical Guidelines Program: Screening for Anal Dysplasia and Cancer in Patients with HIV (here)
- Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV: What's new in the guidelines; August 2020 (here)
- Guidelines for the Prevention and Treatment of Opportunistic Infections in HIV-Exposed and HIV-Infected Children: Recommended Immunization Schedule for children (here)
- Center for Disease Control and Prevention: Recommended Adult Immunization Schedule by Medical Condition and Other Indications, United States, 2020 (here)
- Health Resources Services Administration (HRSA) HIV AIDS Bureau Performance Measures (here)

1 INTAKE, ELIGIBILITY & ANNUAL RECERTIFICATION REQUIREMENTS

The Ryan White HIV/AIDS Program has eligibility criteria as residency, financial, and medical. HRSA requires Ryan White customers to maintain proof of eligibility annually. Supporting documentation is required to demonstrate patient eligibility for Ryan White Services.

A. INITIAL ELIGIBILITY DETERMINATION

HIV-POSITIVE STATUS: WRITTEN DOCUMENTATION FROM A MEDICAL PROVIDER OR LABORATORY REPORTS DENOTING VIRAL LOAD.

1. **Residency:** The following are acceptable proof of meeting the requirement for residency:

   - Current lease or mortgage statement
   - Deed settlement agreement

Current driver's license

- Current voter registration card
- Current notice of decision from Medicaid
- Fuel/utility bill (past 90 days)
- Property tax bill or statement (past 60 days)
- Rent receipt (past 90 days)
- Pay stubs or bank statement with the name and address of the applicant (past 30 days)
- Letter from another government agency addressed to applicant
- Active (unexpired) homeowner's or renter's insurance policy
- DC Healthcare Alliance Proof of DC Residency form
- If homeless, a written statement from case manager, facility or a letter from landlord that customer is a resident

2. **Income:** Patient income may not exceed 500% of the Federal Poverty Level (FPL). Income sources should be reported by the applicant and any household members for whom applicants have legal responsibility. For each income source the applicant must indicate the gross amount, how often the income is received, and whether it is your income or a household member's from each source.

   The following are acceptable forms of proof of income:

   - Pay stubs for the past 30 days. The pay stub must show the year to date earnings, hours worked, all deductions, and the dates covered by the paystub.
   - A letter from the employer showing gross pay for the past 30 days, along with a copy of the most recent income tax return
   - Business records for 3 months prior to application, indicating type of business, gross income, net income, and most recent year's individual income tax return. A statement from the applicant projecting current annual income must be included

- Copy of the tenant’s lease showing patient as the landlord and a copy of their most recent income tax return

- SSD/SSI award letters, unemployment checks, social security checks, pension checks, etc. from the past 30 days

- Zero income attestation form and/or a letter from a supporting friend or family member stating how they support the applicant

B. Intake

To establish a care relationship, the customer intake must include the collection of the following demographic information:

1. Date of intake
2. Name and signature of person completing intake.
3. Customer name, address and phone number
4. Referral source, if appropriate
5. Language(s) spoken and/or preferred language of communication.
6. Literacy level (customer self-report)
7. Emergency contact information
8. Communication method to be used for follow-up.
9. Demographics (sex at birth/current gender/date of birth/race/ethnic origin)
10. Veteran status
11. Any other data required for the CareWare system.
12. Any other service-specific data
13. Documented explanation about the services available within the provider agency and within the Ryan White Program

C. MAINTENANCE OF ELIGIBILITY

To maintain eligibility for Ryan White services, providers must conduct annual eligibility confirmations to assess if the customer's income and/or residency has changed. RWHAP providers are permitted to accept a customer's self-attestation of 'no change' when confirming eligibility, however, self-attestation could be used every other annual confirmation and not to be used in two consecutive years.

SPECIAL STRATEGY FOR HIV CARE IN DISTRICT OF COLUMBIA:
RED CARPET ENTRY PROGRAM AND RAPID ANTIRETROVIRAL THERAPY

Red Carpet Entry (RCE) was introduced in March of 2010 and designed to facilitate expedited entrance into the HIV medical care system for District residents who have been newly diagnosed with HIV/AIDS or who have fallen out of care. Red Carpet Entry Providers commit to providing patients with an appointment with an HIV specialist within **72 hours** following initial clinic contact, a designated RCE-site contact or "concierge" to facilitate the first appointment, and a password phrase that would enable a patient to discreetly ask for services once they arrived at the site.

1. Clients seeking RCE referral may use the RCE site specific password phrase such as "I would like to make an appointment with Dr. White" or ask for "Red Carpet Entry"

2. All members of the clinic staff who have initial contact with public (i.e. clinic receptionist, triage staff, or unit clerk) should be aware of RCE password phrase and RCE program to ensure proper linkage of client to RCE concierge

3. The minimum level of care for HIV requires patients to receive the following screenings or referrals during their first appointment with an HIV provider:
    - Antiretroviral Medications (Rapid Antiretroviral Therapy (ART))
    - Confirmatory HIV test
    - Viral Load and CD4 lab work
    - Tuberculosis test
    - Hepatitis test
    - STD testing

HAHSTA is available to provide technical assistance to support the implementation and evaluation of the Red Carpet Entry Program. If RCE providers encounter questions or concerns related to the Red Carpet Entry Program, they are encouraged to contact the D.C. Department of Health HIV/AIDS, Hepatitis, STD at email redcarpet@dc.gov. More information can be found on https://dchealth.dc.gov/red-carpet-entry-program

The District of Columbia Department of Health (DC Health) supports evidence-based, patient centered initiatives to reduce HIV transmission, improve the lives of people diagnosed with HIV, and reduce health disparities. DC Health recommends rapid ART initiation as soon as possible following HIV diagnosis. For more information see DC Health Notices (here)

Standards

These standards are designed to ensure consistency among Part A services provided as part of the District of Columbia's EMA continuum of care for PLWH. These are minimum standards for the provision of the OAHS service. Sub- recipients and individuals may exceed these standards. These standards do not supersede the scope of practice for all the eligible practitioners and complement the HHS HIV treatment guidelines.

The following aspects are highlighted in this document:

- Red Carpet Entry Program and RAPID ART
- Comprehensive medical history (baseline)
- Comprehensive Physical Examination
- Follow-Up Visits/Progress of Treatment
- Routine Laboratory and Diagnostic Assessments
- Antiretroviral Treatment
- Prevention and Treatment of Opportunistic Infections and Vaccines
- Health promotion and Psychosocial Assessments
- Coordination and Linkage to services
- Case Closure

In this standard, when the term *"clinically indicated"* is used, it refers to the need to perform tests and/or examinations that could have clinically relevant benefits for the health outcome, could assess response to therapy, or address a symptom or functional problem. The provider must clearly document the clinical rationale that governs the decision for performing the examination or test.

STANDARD I: COMPREHENSIVE MEDICAL HISTORY (BASELINE)

Providers must ensure patients undergo triage at intake to determine if urgent or emergent care is needed and then treat as appropriate.

Providers should try to obtain and document efforts to obtain medical records from past medical providers. These records must include documentation of HIV infection. All HIV positive test must be reported in accordance with the Mandatory reporting of diseases to the appropriate department of health in accordance with the DC Municipal Regulations.

Providers must elicit a complete and comprehensive medical history at baseline within two visits or four weeks, whichever comes first.

	Highlighted Elements of the Comprehensive History	Measures
Assess General History	Review sources of past medical care; obtain medical records whenever possible Past hospitalizations, past and current illnesses Family History Tuberculosis history Possible recent exposure to tuberculosis History of positive TST (TB skin test, PPD), TB disease, or treatment of latent TB infection History of hepatitis Current prescription and non-prescription medicines, including complementary and alternative medicines and hormones Vaccination history Reproductive history, including pregnancies, births, termination of pregnancy; current contraceptive use and needs Transfusion or blood product history, especially before 1985 Allergies Travel history/place of birth Occupational history and hobbies Pets/animal exposures	Documentation in patient' medical records
Assess HIV treatment and Staging	HIV exposure history Date and place of the diagnosis Route of exposure, if known Most recent viral load and CD4 count Nadir CD4 and peak viral load Drug-resistance testing Current and previous ART regimens and date of initiation of ART therapy Previous adverse ART drug reactions Opportunistic infections (OI) Previous adverse reactions to drugs used for OI prophylaxis Providers who have been involved in the patient's HIV treatment	Documentation in patient medical records

	Highlighted Elements of the Comprehensive History	Measures
	Patient's understanding of HIV disease and treatment	
Assess Traumatic Life Events Assess Mental Health	Mental health diagnoses Psychotropic medications Past psychiatric hospitalizations History of treatment and barriers to treatment Contact information for mental health providers if applicable	Documentation in patients' medical record
Assess Substance Use	Types of drugs; past and current use Street drugs—marijuana, cocaine, heroin, methamphetamine, 3,4-Methylenedioxymethamphetamine (MDMA)/ecstasy Medical Marijuana Illicit use of prescription drugs Alcohol Tobacco Frequency of use and usual route of administration Risk behaviors—drug/needle sharing, exchanging sex for drugs, sexual risk-taking while under the influence of drugs or alcohol History of treatment and barriers to treatment Contact information for substance abuse treatment providers if applicable	Documentation in patients' medical record
Assess Sexual History	Current sexual activity History of sexually transmitted infections Sexual practices—vaginal, anal, oral Gender identity and sexual orientation Gender of sex partners Risk behavior assessment, including use of latex or polyurethane barriers, number of partners, sex while intoxicated or high	Documentation in patients' medical records

	Highlighted Elements of the Comprehensive History	Measures
Obtain Information for Community - Based Disease Intervention Services (DIS) Assess PrEP for negative Partners	At the initial visit ask if all sex and needle-sharing partners have been informed of their exposure to HIV. At routine follow-up visits ask if patient has any new sex or needle-sharing partners who have not been informed of their exposure to HIV. Elicit partner names and contact information for Disease Intervention Services. Identify, locate and interview the sexual contacts of people newly diagnosed with HIV and STIs and others at risk for behavioral or other factors (also known as contact tracing) and then refer them for testing care and treatment (Commonly referred to as Partner Services Obtain history about patients' negative partners who were prescribed pre-exposure prophylaxis (PrEP) or post-exposure prophylaxis (PEP) Patients in sero-discordant relationships should be educated about options for PrEP or PEP for their partners. PrEP and PEP should be prescribed for these partners or referred to their primary care for PrEP or PEP	Documentation in patients' medical records
Conduct Psychosocial Assessment	Housing status Employment and insurance status Educational level Family and partner contacts Stability of personal relationships Domestic violence screening Legal Issues Living will and health care proxy Permanency planning for dependent children (for patients with severely advanced disease) Advance directives, durable powers of attorney, living wills and other planning documents, including physician's orders for life sustaining treatment (POLST) and do not resuscitate (DNR) status, should be addressed at the beginning of treatment and at any appropriate time in the course of the illness.	Documentation in patients' medical records

	Highlighted Elements of the Comprehensive History	Measures
Review of Systems	Constitutional, Head/Eyes/Ears/Nose/Throat, Pulmonary, Cardiac, Abdominal, Genitourinary, Obstetrics and Gynecological, Musculoskeletal, Neurologic, Dermatologic	Documentation in patients' medical record

STANDARD II: COMPREHENSIVE PHYSICAL EXAMINATION

Providers must perform a baseline and annual comprehensive physical examination, with particular attention to areas potentially affected by HIV. The comprehensive physical exam should address all systems, must include measurement of all vital signs and must be completed within two visits or one month, whichever comes first.

Standard	Elements of the physical exam	Measures
Comprehensive physical assessment will be completed by physician, NP, PA and updated, as necessary. Comprehensive assessment and updates/ follow-up treatment (as necessary) ● Temperature, vital signs, height and weight ● Pain assessment ● Ophthalmologic examination ● Ears, nose, and throat ● Oral exam ● Dermatological ● Lymph node ● Pulmonary	Temperature, vital signs, height and weight Pain assessment • Ophthalmologic examination • Ears, nose, and throat Oral exam • Dermatological • Lymph node • Pulmonary • Cardiac • Abdominal • Genital • Rectal	Documentation in patients' medical records

Standard	Elements of the physical exam	Measures
• Cardiac • Abdominal • Genital • Rectal • Neurological	• Neurological	
Problem List Providers must develop and document a problem or needs list with information gathered from the comprehensive • medical history, • physical examination, and • laboratory and diagnostic testing. .		Documentation in patients' medical records
Medical Treatment Plan Providers must develop a medical treatment plan. These outlines: • time-specific • measurable goals, interventions, • medications prescribed and/or • specialty care referrals These must address the problems/needs identified on the list. The patient must have a central role in making decisions regarding the plan, but only the provider must sign the plan**.**	Documentation in the patient's medical records must reflect the patient's participation and agreement with the medical plan.	Signed treatment plan in patient's medical record
Providers must perform a gynecologic examination in all women living with HIV or refer		Documentation of gynecological exam or referral in patient record

Standard	Elements of the physical exam	Measures
them to a gynecologist at baseline and at least annually		
Providers must refer women with cervical High-grade Cervical Squamous Intraepithelial Lesions (HSIL) and any patient with abnormal anal physical findings, such as ● warts, ● hypopigmented or ● hyperpigmented plaques/lesions, ● lesions that bleed, or any ● other lesions of uncertain etiology, for high-resolution colposcopy and anoscopy respectively and/or examination with biopsy of abnormal tissue and for subsequent treatment if indicated.		Documentation of treatment or referral on patient medical records
Providers must ascertain whether their patients have a regular oral health provider and should refer all PLWH for annual hygiene and intraoral examinations, including dental caries and soft-tissue examinations.	Examination of the oral cavity and mucosa	Documentation of oral examination on file or dental referral on file
Providers must perform a comprehensive assessment at baseline and annually: ● Substance use and ● Mental health Providers must incorporate selected brief screening instruments such as the PHQ2,	The chosen screening instruments should be approved by program monitor and tailored for optimal use at initial, annual, and as needed for interim visits and adjusted for the patient's mental health or substance use history.	Documentation of assessment in medical records

Standard	Elements of the physical exam	Measures
PHQ9, GAIN-SS, CAGE, MMS; into the assessment process for both categories		

STANDARDS III: FOLLOW - UP VISITS/PROGRESS OF TREATMENT

Patients should have follow-up visits scheduled according to the DHHS guidelines, three to four months and more frequently when on ART, new into care or experiencing virologic failure. There may be some exceptions, at practitioner's discretion when patient have demonstrated long-term stability and adherence to treatment, frequency may be altered, reduced, or increased. Frequency of visits may also change if a patient is experiencing acute problems that requires intense monitoring. Provider should accommodate such need to ensure quality of care is provided. At minimum, a medical visit for a returning patient will include a problem focused history, problem-focused examination, and straightforward medical decision-making.

Standards	Elements of Follow-up visits	Measures
Follow-up visits should be scheduled more frequently at entry to care, when starting or changing ART regimens, or for management of acute problems Routinely, Follow-up visits for patients receiving ART therapy should be scheduled every three to six months, except at the practitioner's discretion when a patient has demonstrated long-term stability and adherence in his/her medical regime. Monitor one to three months if adherence is unstable. DHHS guidelines require at least two visits annually.	Follow-up visits should be scheduled every three to six months for patients who are not receiving ART therapy. During first 2 years of ART, or if viremia develops while patient is on ART, or if CD4 count is <300 cells/mm²	Patient medical record to confirm frequency
Follow-up visits: OAHS should conduct Follow-up	• Temperature, vital signs, height and weight	Documentation of referrals and/or follow-up visits in patient medical record.

Standards	Elements of Follow-up visits	Measures
visits according to DHHS guideline. For stable patients on treatment, labs at least every 6 months. Annual visits should be conducted by OAHS services: Annual (at minimum) cervical Pap smears for women Annual (at minimum) anal and rectal exams Annual (at minimum) PPD test, chest X-ray and prophylaxis as indicated Advance directives and planning documents addressed at treatment initiation and as indicated Referral for ophthalmic examination for patients with CD4 counts below 50 Family planning/contraception (for	• Problems list and updates including sexual history • Pain assessment • Treatment plan adherence • Viral load at regular intervals and prior to and after ART treatment initiation • Suboptimal viral load suppression • Laboratory tests • Opportunistic infection prophylaxis and documentation Diagnosis of HSIL or atypical squamous cells of undetermined significance should be followed with colposcopic examination of the lower genital tract. Inquire about last menstrual period and contraception, when appropriate Baseline and periodic anal Pap smears for high-risk populations may be considered, with appropriate referral to specialists for high resolution anoscopy for those patients with abnormal results. For patients who have no history of TB or positive PPD tests, a PPD test or Interferon-Gamma Release Assay (IGRA) should be performed at least annually, with results recorded. Record attempts to follow up with patients who do not return for PPD reading. For all positive IGRA tests and PPD tests of at least five millimeters of induration, a chest X-ray should be obtained to rule out active pulmonary disease, and, if appropriate, prophylaxis	Documentation of annual screening in patient medical records and treatment if clinically indicated Patient medical record to confirm referrals and/or content of follow-up visit

Standards	Elements of Follow-up visits	Measures
women) and safer sex discussions and documentation	should be given. If there is a history of a positive PPD or IGRA, any record of prophylactic treatment should be noted in the chart. Risk assessment for TB should be assessed annually with a symptom screen to detect acute disease (CDC: Treatment of LTBI and TB for persons with HIV and Clinical info HIV.gov> Mycobacterium tuberculosis)	
OAHS services should provide patient encounters: Encounters will include: ● HIV and STI prevention messages ● Treatment adherence counseling and support as needed ● Nutrition screening, and referrals as needed ● Social living conditions review ● Patient education on HIV disease, symptoms ● Medications and treatment regimens	Regular discussions of family planning and contraception should be conducted with female patients. For patients who are pregnant, some medical providers may wish to refer their pregnant women with HIV to an OB specialist in HIV.	Documentation of encounters in patient's medical record

STANDARD IV: ROUTINE LABORATORY AND DIAGNOSTIC TESTING

Outpatient Ambulatory Health Services (OAHS) programs must have access to all laboratory services required to comply fully with established practice guidelines for HIV prevention and risk reduction and for the clinical management of HIV disease. Providers must order appropriate laboratory assessments and screening tests for management of PLWH according to DHHS guidelines. All clinical and immunological monitoring should be followed according to the most up to date guidelines as published in the DHHS guidelines available at **https://clinicalinfo.hiv.gov/en/guidelines**

Programs must assure timely, quality lab results, readily available for review in medical encounters. Baseline lab tests (preferably at fasting) for all PLWH should include:

- HIV-RNA viral load
- CD4 count
- HIV drug resistance testing
- Syphilis serology
- Gonorrhea and Chlamydia – Urine or Cervical, Rectal, and Oral
- Toxoplasma gondii antibody screening (for people with low CD4 count)
- Urinalysis
- Hepatitis A screening for those not previously vaccinated
- Hepatitis B and C serology* * If the serology for hepatitis C is reactive, then tests to determine whether the patient has chronic hepatitis C infection should be done. If a quantitative hepatitis C viral load is indicated, and if the virus is present, the patient should be counseled and evaluated for hepatitis treatment, and as appropriate, treatment should be initiated.
- Complete Blood Count (CBC)
- Liver function tests
- Blood Urea Nitrogen (BUN)
- Creatinine
- Protein
- Albumin
- Glucose
- Lipid panel
- Chest X-ray (if the PPD or IGRA is positive)
- Purified Protein Derivative (PPD) or IGRA (Quantiferon)
- Cervical Pap smear (if not done in past year)

Follow-up and ongoing lab tests for patients should include, at a minimum:

- Annual: CBC, liver function tests, BUN, cholesterol, triglycerides (preferably fasting)
- Every six months: CD4, HIV-RNA, syphilis serology, urine GC/Chlamydia and rectal GC, oral GC/Chlamydia testing for sexually active patients based on risk behavior in accordance with CDC STD Guideline

Follow-up and ongoing lab tests for patients on ART should include:

- CBC, liver function tests, BUN, creatinine, glucose, cholesterol, triglycerides (preferably fasting), CD4, HIV-RNA and syphilis serology. Urine GC/Chlamydia, rectal GC, and

oral GC/Chlamydia testing should be offered for sexually active patients based on risk behavior CDC Sexually Transmitted Guidelines.

DRUG RESISTANCE TESTING At baseline and again when appropriate, OAHS practitioners may order drug resistance testing to measure a patient's pattern of resistance of HIV to antiretroviral medications. Genotypic testing looks for viral mutations and is expected for all naïve patients, and phenotypic testing measures the amount of drug needed to suppress replication of HIV. By using resistance testing, practitioners can determine if the virus is likely to be suppressed by each antiretroviral drug. This information is used to guide practitioners in prescribing the most effective drug combinations for treatment. Drug resistance testing services will be based upon most recent established guidelines and standards of care including the PHS Guidelines and the Infectious Disease Society of America Guidelines, as well as the DHHS Panel on Antiretroviral Guidelines for Adults and Adolescents' Recommendations for HIV Viral Load Testing and the CDHS's Recommended General Clinical Guidelines.

Counseling and education about drug resistance testing must be provided by the patient's medical practitioner, RN and/or other appropriate licensed health care provider (if designated by the practitioner). Patients must be fully educated about their medical needs and treatment options according to standards of medical care. Patients must be given an opportunity to ask questions about their immune system, antiretroviral therapies, and drug resistance testing. All patient education efforts will be documented in the patient record.

Routine Laboratory and Diagnostic Assessments (Laboratory Schedule, pages 1 - 4)		
Standards	**Elements**	**Measures**
Basic laboratory assessments	Laboratory bundle (CBC, Chemistry, LFTs, CBC with Differential, Random or fasting Glucose, Urinalysis, Pregnancy Test. (See Table 3. Laboratory Testing Schedule for Monitoring People with HIV Before and After Initiation of Antiretroviral Therapy)	Baseline and every 3 to 6 months or as clinically indicated.
Immunologic Assessment	CD4 count	Baseline, ART initiation or modification, during first 2 years of ART or if viremia develops while patient is on ART, or if CD4 is <300 cells/mm³ Every 12 months after 2 years on ART with

Routine Laboratory and Diagnostic Assessments (Laboratory Schedule, pages 1 - 4)		
Standards	**Elements**	**Measures**
		consistently viral load, CD4 count 300-500 cells/mm³ CD4 count >500 cells/mm³, CD4 count is optional If ART initiation is delayed, every 3 to 6 months.
Virologic Assessment	Quantitative HIV RNA testing for viral load assessment.	Baseline and every 3 to 6 months Before ART, 2 weeks and 8 weeks on ART Entry into care, ART initiation or modification, Treatment failure and when clinically indicated
Resistance Testing Resistance testing should be performed (if feasible) for patients new to care before ART therapy, when viral failure to ART has been demonstrated and/or when suboptimal suppression of viral load occurs	Genotype testing ***For guidance on resistance testing please refer to the Guidelines for the Use of Antiretroviral agents in HIV-1 infected Adults and Adolescents at Here***	
Hepatic A and B Assessment	Hepatitis A, B serology (HBsAb, HBsAg, HBcAb total)	Entry into care (Baseline) and ART initiation or modification, may repeat if patient is nonimmune and does not have chronic HBV infection. Repeat every 12 months if patient is nonimmune and does not have chronic HBV infection And if clinically indicated including prior to starting HCV DAA (HCV Guidance)
Hepatic C Assessment Entry into Care, Repeat HCV screening for at-risk patients every 12 months and if	Hepatitis C Screening (HCV antibody or if indicated, HCV RNA)	Documentation in patients' medical records

Routine Laboratory and Diagnostic Assessments (Laboratory Schedule, pages 1 - 4)		
Standards	**Elements**	**Measures**
clinically indicated		
Metabolic assessment Baseline and annually	Fasting Lipid panel including cholesterol	Documentation in patient's medical records.
Nutritional assessment Baseline and periodic assessment as clinically indicated	A nutrition assessment is an in-depth evaluation of both objective and subjective data related to an individual's food and nutrient intake, lifestyle, and medical history. The assessment leads to a plan of care, or intervention, designed to help the individual either maintain the assessed status or attain a healthier status.	Documentation in patient's medical records.
Tuberculosis evaluation Baseline	Providers must obtain a TST (tuberculin skin test, commonly known as PPD) or other FDA-approved test for patients with no previous documented history of TB or no previous positive TST Chest x-ray for patients known to have a history of TB or known to be TST positive or suspected to be anergic. After active tuberculosis has been excluded, providers must prescribe TB prophylaxis when a TST results in induration of ≥5 mm or when another FDA-approved test indicates the presence of latent TB infection CDC: Treatment of	Documentation of result at baseline in patient's medical records.

Routine Laboratory and Diagnostic Assessments (Laboratory Schedule, pages 1 - 4)		
Standards	**Elements**	**Measures**
	LTBI and TB for persons with HIV and Clinical info HIV.gov> Mycobacterium tuberculosis)	
Screening for sexually transmitted infections Baseline and as clinically indicated; every 3- 6 months for those patients with continued high-risk behavior See link Here.	RPR or VDRL for syphilis with verification of positive test by confirmatory FTA-Abs or TP-PA Gonorrhea: Urogenital Gonorrhea Oral Gonorrhea Rectal Gonorrhea And Chlamydia NAAT or probe Urogenital Chlamydia Rectal Chlamydia	Documentation of all results in patient's medical records

Routine Laboratory and Diagnostic Assessments (Laboratory Schedule, pages 1 - 4)		
Standards	**Elements**	**Measures**
Cytologic Screening Baseline, then annually for 2 years. Then if normal results, then every 3years as long as results are normal. Baseline for every patient with a history of receptive anal intercourse (regardless of gender or sexual orientation) and for every male patient with a history of anal warts (regardless of sexual orientation) and every female with a history of anogenital warts and/or cervical dysplasia. If the results are normal, the PAP smear should be repeated in six months. If the second PAP smear is still negative, then repeat annually. Any abnormality in the PAP smears is an indication for referral for high resolution anoscopy and biopsy of suspected areas.	Cervical pap tests After a patient has completed treatment for an abnormal cervical biopsy test, clinician should repeat cytologic tests at 6 months, then annually until 2 tests in a row screen negative, then every 3 years Cervical Screening Guideline, New York Update. Anal pap tests *(these are strongly recommended but not yet mandatory*) Anal Screening Guideline, New York Update	Documentation of results in patient's medical records

STANDARD V: ANTIRETROVIRAL TREATMENT AND OPPORTUNISTIC INFECTIONS

A. ANTIRETROVIRAL TREATMENT:

More than 30 antiretroviral (ARV) drugs in seven mechanistic classes are Food and Drug Administration (FDA)-approved for treatment of HIV infection. These seven classes include the nucleoside/nucleotide reverse transcriptase inhibitors (NRTIs), non-nucleoside reverse transcriptase inhibitors (NNRTIs), protease inhibitors (PIs), integrase strand transfer inhibitors (INSTIs), a fusion inhibitor, a CCR5 antagonist, and a CD4 T lymphocyte (CD4) post-attachment inhibitor. In addition, two drugs, ritonavir (RTV) and cobicistat (COBI) are used as pharmacokinetic (PK) enhancers (or boosters) to improve the PK profiles of PIs and the INSTI elvitegravir (EVG).

The initial ARV regimen for a treatment-naive patient generally consists of two NRTIs, usually abacavir/ lamivudine (ABC/3TC) or either tenofovir alafenamide/emtricitabine (TAF/FTC) or tenofovir disoproxil fumarate/emtricitabine (TDF/FTC), plus a drug from one of three drug classes: an INSTI, an NNRTI, or a boosted PI. As shown in clinical trials and by retrospective evaluation of cohorts of patients in clinical care, this strategy for initial treatment has resulted in suppression of HIV replication and CD4 count increases in most person with HIV. Additional data now support the use of the two drug regimen dolutegravir (DTG) plus 3TC for initial treatment of people with HIV(DHHS Guideline).

FOR ANTIRETROVIRAL (ART) TREATMENT CONSIDERATIONS, PLEASE REFER TO THE (DHHS GUIDELINE WHICH INCLUDES RECOMMENDATIONS REGARDING INITIATION OF ART THERAPY, SELECTION OF AN ART REGIMEN, MONITORING FOR ART-SPECIFIC SIDE EFFECTS, OPTIMIZING TREATMENT ADHERENCE, AND CHANGING REGIMENS AT

Standards	Elements	Measures
ART therapy will be prescribed in accordance with DHHS Guidelines for the Use of Antiretroviral Agents in HIV-infected Adults and Adolescents	Same day Rapid ART available in the DC	Documentation in patient's medical record
Patients will be part of treatment decision-making process.		Documentation of patient's signature in the plan of care in medical record
Health Provider must follow Drug resistance testing in accordance with HHS HIV Treatment Guideline, must follow most recent, established resistance testing guidelines, including genotypic testing on all naïve	Resistance testing should be performed (if feasible) for patients new to care before ART therapy, when viral failure to ART has been demonstrated and/or when suboptimal suppression of viral load occurs	Documentation of patient's in medical record

Standards	Elements	Measures
patients.		
For patients who need ADAP, will be referred to AIDS Drug Assistance Program (ADAP) enrollment site. As indicated, patients will also be referred to medical care coordination programs for public benefits concerns.	https://dchealth.dc.gov/DC-ADAP	Documentation of referrals in patient's in medical record
Outpatient Ambulatory Health Services (OAHS) programs must exercise every effort and due diligence consistent with their ethical responsibilities to ensure that patients can get Antiretroviral medications and other needed medications not on the ADAP and local formularies.		Documentation of medications not on ADAP formulary obtained by patient in medical record
Medical providers will refer patients with more acute treatment adherence needs to specialized treatment adherence or treatment education programs.		Referral(s) noted in assessment and/or patient medical records, as applicable.
Medical provider or treatment adherence counselors may provide one-on-on patient support contacts to support patients as they seek and receive services. Support can include: • Accompanying patients to medical visits and clinical trials visits • Helping patients understand HIV disease and treatment options • Helping patients with adherence	• Use adherence-related tools to complement education and counseling interventions (e.g., text messaging, pill box monitors, pill boxes, alarms). • Use community resources to support adherence (e.g., visiting nurses, community workers, family, peer	Progress notes on file in patient chart to include (at minimum): • Date, time spent, type of contact • What occurred during the contact • Signature and title of the person providing the contact • Referrals provided and interventions made (as appropriate) • Results of referrals,

Standards	Elements	Measures
issues • Providing emotional support	advocates, transportation assistance). • Use patient prescription assistance programs (see above, under "Provide needed resources"). • Use motivational interviews. • Provide outreach for patients who drop out of care. • Use peer or paraprofessional treatment navigators. • Recognize positive clinical outcomes resulting from better adherence. • Arrange for DOT in persons in substance use treatment (if feasible). • Enhance clinic support and structures to promote linkage and retention (reminder calls, flexible scheduling, open access, active referrals, and improved patient satisfaction).	interventions and progress made toward goals in the individual service plan (as appropriate)

B. Prevention and Treatment of Opportunistic Infections

Refer to current guidelines and prevailing standards for prophylaxis of opportunistic infections from DHHS Guidelines for Opportunistic Infections (Recommendations for Treating Opportunity Infections). Documentation of current therapies should be maintained on all patients receiving prophylaxis.

- For the diagnosis, prevention and treatment of Opportunistic Infections please refer to the Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-infected Adults and at Guidelines for Treatment of Opportunistic Infections for HIV

C. Vaccination Schedules for HIV positive Individuals

- For vaccination schedules for HIV positive children, please refer to the Recommended schedules for HIV positive adults at Recommended Immunization Schedule for Children
- vaccination schedules for people with medical condition including HIV positive individuals the Recommended Adult Immunization Schedule by Medical Condition and Other Indications, United States, 2020 Recommended Immunization Schedule for Adults

STANDARD VI: HEALTH PROMOTION AND PSYCHOSOCIAL ASSESSMENTS

The adoption of healthy living and reduction in risk behaviors among HIV-positive people leads to a substantial improvement in the quality of life and a reduction of rates in HIV transmission. It is understood that information alone, especially on subjects such as sexual activity and drug use, cannot be expected to change patient's behavior. However, providers can play a key role in helping patients to understand the transmission risk of certain types of behavior and help to establish and maintain safer practices, safe disclosure practices and begin personal prevention strategies for themselves and their partners.

Standards	Elements	Measures
Practitioners will discuss health maintenance with patients annually (at minimum), including: • Cancer screening (per USPSTF: Prostrate Cancer Screening 2018 Breast Cancer USPSTF:Recommendation for Breast Cancer 2016; BRCA-	All health promoting and maintenance education provided. Counseling on use of non-conventional medication and herbal supplements can also be discussed	Annual health maintenance discussions will be documented in patient medical records.

Standards	Elements	Measures
Related Cancer Risk Assessment Colon Cancer, USPSTF: Colorectal Cancer Screening 2016 Cervical Cancer ; USPSTF: Screening for Cervical Dysplasia and Cancer 2018; NYDOH screening for Cervical Cancer Anal dysplasia and Cancer; NYSDOH screening for Anal Dysplasia Lung Cancer: USPSTF Lung Cancer Screening • Hepatitis screening, vaccination • TB screening Influenza vaccine • Tetanus/diphtheria update • Pneumovax • Meningococcal vaccine for high-risk MSM and those who request it • Family planning • Counseling on safer sex and STI screening • Counseling on food and water safety • Counseling on nutrition, Exercise and diet • Harm reduction for alcohol and drug use • Smoking cessation:		
HIV Education	HIV education	Documentation in

Standards	Elements	Measures
Providers must educate the customers about HIV at baseline (new to care), annually and as needed. This must include: -The natural history of HIV disease -Goals of HIV disease management -Principles of HIV treatment -Side effects of medication and -Self-monitoring for commonly encountered symptoms	HIV life cycle Goals for treatment Antiretroviral medications Symptoms of HIV	customer's record that these elements have been addressed or are in process.
Risk Reduction Counseling Providers, at <u>each</u> visit with an HIV-positive person, must provide risk reduction counseling to include screening for high-risk behavior. -Provide patients to routine HIV risk reduction counseling -Discussion of safer sexual practices -Discussion of PrEP use by Partners -Link to support for addressing these behaviors	Providers must recommend the correct and consistent use of latex or, when latex allergies exist, polyurethane male condoms and should discuss the option of using polyurethane female condoms. Providers must emphasize that transmission of HIV may occur during unprotected sex, even when patients have undetectable HIV plasma viral loads. Providers must instruct patients in the proper use of condoms, dental dams, and other barriers to reduce the risk of HIV transmission The need for PrEP for sexual partners	Documentation in patient's record that these elements have been addressed or are in process.
Disclosure for Social Support Providers must routinely discuss with patients the importance of disclosure for social support and encourage safe disclosure as needed.	Those who do not disclose for social support have poorer health outcomes than those who do	Documentation of disclosure for social support assessments in patients' medical records Documentation in patient's record that these elements have been addressed or are in process.

Standards	Elements	Measures
Promotion of Mental Health Providers must routinely inquire about mental health needs in a culturally appropriate and sensitive manner and link patients to services as needed. Providers must use appropriate screening tools (e.g., PHQ2, PHQ9, CAGE, MMS, GAIN-SS or other HAHSTA/DC Health approved tools) when performing assessments.		Documentation in patients' medical record that these elements have been addressed or are in process
Substance Abuse Providers must use appropriate screening tools (such as PHQ2, PHQ9, CAGE, MMS, GAIN-SS or other HAHSTA/DC Health approved tools) when performing assessments Providers **must not** prevent a patient who is actively abusing substances from obtaining access to HIV treatment even if the patient is not participating in substance abuse treatment	Providers must routinely inquire about substance abuse and link patients to services as needed. Substance abuse can cause serious health risks for many including poor adherence to medications and increased disease progression. Under the influence of substances individuals may be more likely to engage in risky behaviors	Documentation in patient record that these elements have been addressed or are in process
Treatment Adherence Providers must assess and encourage adherence to both medication and care at each visit. Providers must provide adherence support or link patients to treatment adherence services as clinically	This is adherence to both a comprehensive care program and an antiretroviral medication regimen. Several factors can interfere with treatment adherence; thus providers need to be knowledgeable and assist patients in addressing them routinely throughout treatment.	Documentation of treatment adherence provided as part of the plan of care in medical records

Standards	Elements	Measures
indicated. Providers must regularly exchange information with patient's treatment adherence counselor and medical case manager.		
Smoking Cessation Providers must assess smoking status, provide strategies to promote cessation. Linkages to smoking cessation programs and pharmacotherapy should be provided if the patient is interested.	Smoking Cessation Smoking increases risk of thrush, coronary artery disease and bacterial pneumonia. It has been found to reduce the effectiveness of ART treatment in women. HIV infection further increases the risk of lung and other cancers associated with smoking	Documentation of smoking assessments, intervention provided and referral to treatment in medical records
Domestic Violence Providers must screen all patients for current and lifetime domestic violence (both as survivors and as perpetrators) at baseline and annually	Domestic violence Providers must screen for domestic violence in a culturally sensitive approach	Documentation of screening and referral to intervention if positive on patient's medical records

STANDARD VII: COORDINATION OF CARE, LINKAGE TO SERVICES AND RETENTION IN CARE

As part of the patient's treatment plan, services outside of the primary care provider's agency may be necessary. The provider is responsible for ensuring that the patient is linked to these services and the patients care is coordinated. The services may include specialty medical care, mental health treatment, medical case management, substance use prevention and treatment, housing and social support services.

Providers must ensure that linkages include a defined process for information exchange and feedback and a mutually understood method between referrer and referee for enrolling patients in services.

Providers must actively participate in the coordination of services for their patients. This must include the continuous interchange and exchange of patient treatment information between the patients designated primary medical care provider and external service providers.

Providers must create linkages and/or referrals that match the patient's self-identified priorities, as these are more likely to be completed; the services need to be responsive to the patient's needs and appropriate for the patient's culture, language, gender identity and expression, sexual orientation, age, and developmental level.

Providers must use medical case management as appropriate to enhance the coordination of care provided by agencies such as home care, nutrition services, and nursing services and to prevent duplication of services. Providers must regularly involve medical case managers in case reviews and conferences to discuss all issues that may affect a patient's ability to adhere to care.

A critical support in the coordination of care is the patient's medical case manager. Emphasized in both the Health and Human Resources Administration (HRSA) definition of medical case management at PCN 16-02 and, DC Health/HAHSTA Medical Case Management Guidelines is that HIV/AIDS medical case management services focus on 1) retention in medical care and 2) achieving positive health outcomes for patients, particularly the importance of viral load suppression for those on antiretroviral treatment DC MCM Guideline 2014.

Providers must ensure comprehensive care for patients either by providing all services or linking them to essential services for good health and outcomes. From the following table guidance can be obtained to address medical co-morbidities and routine age- and gender-specific care.

Standard	Elements	Measures
Care Coordination & Linkage OAHS programs will provide medical care coordination services either directly or through cooperative agreement. Services are supervised by an RN and a Master's-level patient care manager and include: • Outreach • Intake • Comprehensive assessment/reassessment • Patient acuity assessment • Comprehensive treatment plan • Implementation and evaluation of comprehensive treatment plan • Referral and coordination of care • Case conferences • Benefits specialty services		Documentation of medical care coordination services and/or referral on file in patient medical record

• HIV prevention, education and counseling • Patient retention services		

Retention in Care

Programs will strive to retain patients in OAHS services. To ensure continuity of service and retention of patients, programs will be required to establish a missed appointment policy. Follow-up can include telephone calls, written correspondence and/or direct contact, and strives to maintain a patient's participation in care. Such efforts shall be documented in the progress notes within the patient record. If a pattern of missed appointments persists, patients must be referred to specialized adherence services and/or medical care coordination for support.

Standard	**Elements**	**Measures**
Providers of HIV Outpatient/Ambulatory Health Care should systematically assess retention of patients in care and should implement clinic practices that encourage retention. Programs shall provide regular follow up procedures to encourage and help maintain a patient in medical treatment. Telephone calls · Written correspondence · Direct contact · Other technological means (such as text messaging etc If unable to locate patient, Provider should contact HAHSTA's data-to-Care team after numerous attempts or six months which ever one is first.	A pattern of missed appointments can lead to discontinuity of medical care services and may be related to underlying mental health, substance abuse, financial or other issues	A written policy should be on file at provider agency regarding retention in care. A missed appointment policy should be established and implemented. Documentation of attempts to contact patients at-risk of loss to care should be included in patient records. Document all efforts.

STANDARD VIII: CASE CLOSURE

Case closure is a systematic process for disenrolling patients from Outpatient ambulatory health services. The process includes formally notifying patients of pending case closure and completing a case closure summary to be kept on file in the patient record. All attempts to contact the patient and notifications about case closure will be documented in the patient file, along with the reason for case closure.

Standards	Elements	Measures
OAHS programs will develop case closure criteria and procedures.	Cases may be closed when the patient: ● Relocates out of the service area (out of EMA) ● Has had no direct program contact in the past six months ● Can no longer be located ● Fails to provide updated documentation of eligibility status thus, no longer eligible for services ● Changes his or her primary care provider ● Is incarcerated longer than one year ● Uses the service improperly or has not complied with the patient services agreement ● Exhibits pattern of abuse as defined by agency's policy ● Withdraws from or refuses funded services, reports that services are no longer needed, or no longer participates in the individual service plan	Case closure criteria and procedures on file at provider agency. Patient medical records will include attempts at notification and reason for case closure. Documentation of discharge plan and summary in customer's record with clear rationale for discharge within 30 days of discharge, including certified letter, if applicable. <u>Documentation</u>: Customer's record must include: ● Date services began ● Special customer needs ● Services needed/actions taken, if applicable ● Date of discharge ● Reason(s) for discharge ● Referrals made at time of discharge, if applicable

Standards	Elements	Measures
	• Becomes housed in an "institutional" program anticipated to last for a minimum of 30 days, such as a nursing home, prison, or inpatient program • Has died	

STANDARD IX: QUALITY MANAGEMENT PLAN AND PERFORMANCE MEASURES

Quality Management Plan:

Every agency that provides HIV medical services must implement an HIV Quality Management Program. The HIV quality management program should be actively supported and guided by the formal clinical leadership and senior administration, and appropriate resources should be committed to support quality improvement activities. Program staff should be aware of the quality management infrastructure and understand their role in quality improvement activities. Each HIV quality management program must have a written annual quality management plan that is reviewed and updated routinely by its quality management committee. Program activities must be informed by consumer input and feedback. Consumers may identify additional concerns and issues for improvement of HIV care.

Performance Measures:

HIV Viral Load Suppression

Description: Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/ml at last viral load test during the measurement year.

Numerator: Number of patients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year

Denominator: Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year

Patient Exclusions: None

Data Elements: Does the patient, regardless of age, have a diagnosis of HIV? (Y/N) a. If yes, did the patient have at least one medical visit during the measurement year? (Y/N) i. If yes, did the patient have a HIV viral load test with a result

Prescription of HIV Antiretroviral Therapy:

Description: Percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy1 for the treatment of HIV infection during the measurement year

Numerator: Number of patients from the denominator

Denominator: Number of patients from the denominator prescribed HIV antiretroviral therapy during the measurement year 1

Patient Exclusions: None

Data Elements: Does the patient, regardless of age, have a diagnosis of HIV? (Y/N) a. If yes, did the patient have at least one medical visit during the measurement year? (Y/N) i. If yes, was the patient prescribed HIV antiretroviral therapy1 during the measurement year? (Y/N)

Adult guidelines: "Antiretroviral therapy (ART) is recommended for all HIV-infected 2 individuals to reduce the risk of disease progression. The strength and evidence for this recommendation vary by pretreatment CD4 cell count: CD4 count 500 cells/mm3 (BIII). ART also is recommended for HIV-infected individuals for the prevention of transmission of HIV. The strength and evidence for this recommendation vary by transmission risks: perinatal transmission (AI); heterosexual transmission (AI); other transmission risk groups (AIII)."

Pediatric guidelines: "Antiretroviral therapy (ART) should be initiated in all children with AIDS or significant symptoms (Clinical Category C or most Clinical Category B conditions) (AI*).

• ART should be initiated in HIV-infected infants <12 months of age regardless of

clinical status, CD4 percentage or viral load (AI for infants <12 weeks of age and

AII for infants ≥12 weeks to 12 months).

• ART should be initiated in HIV-infected children ≥1 year who are asymptomatic or have

mild symptoms with the following CD4 values:

Age 1 to <3 years

- with CD4 T lymphocyte (CD4 cell) count <1000 cells/mm3 or CD4

  Percentage <25% (AII)

Age 3 to <5 years

- with CD4 cell count <750 cells/mm3 or CD4 percentage <25% (AII)

Age ≥5 years

- with CD4 cell count <350 cells/mm3 (AI*)
- with CD4 cell count 350–500 cells/mm3 (BII*)

• ART should be considered for HIV-infected children ≥1 year who are asymptomatic or have mild symptoms with the following CD4 values:

Age 1 to <3 years

- with CD4 cell count ≥1000 cells/mm3 or CD4 percentage ≥25% (BIII)

Age 3 to <5 years

- with CD4 cell count ≥750 cells/mm3 or CD4 percentage ≥25% (BIII)

Age ≥5 years

- with CD4 cell count >500 cells/mm3 (BIII)

In children with lower-strength (B level) recommendations for treatment, plasma HIV RNA levels >100,000 copies/mL provide stronger evidence for initiation of treatment (BII).”

HIV Medical Visit Frequency

Description: Percentage of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits.

Numerator: Number of patients in the denominator who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the subsequent 6-month period.

Denominator: Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the first 6-months of the 24-month measurement period.

Patient Exclusions: Patients who died at any time during the 24-month measurement period

Data Elements: Does the patient, regardless of age, have a diagnosis of HIV? (Y/N)

a. If yes, did the patient have at least one medical visit in the first 6 months of the 24-month measurement period? (Y/N)

i. If yes, did the patient have at least one medical visit in the second 6-

month period of the 24-month measurement period? AND was the

patient's last visit in the second 6-month period 60 days or more from the

1st visit in the first 6-month period? (Y/N)

1. Did the patient have at least one medical visit in the third 6-month

period of the 24-month measurement period?

AND was the patient's last visit in the third 6-month period 60 days or more

from the 1st visit in the second 6- month period? (Y/N)

a. If yes,

did the patient have at least one medical visit in the

fourth 6-month period of the 24-month measurement

period?

AND was the patient's last visit in the fourth 6-month

period 60 days or more from the 1st visit in the third 6-

month period? (Y/N)

Adult guidelines: "Several laboratory tests are important for the initial evaluation of patients with HIV upon entry into care, and before and after initiation or modification of antiretroviral therapy (ART) to assess the virologic and immunologic efficacy of ART and to monitor for laboratory abnormalities that may be associated with antiretroviral (ART) drugs.

Table 3 outlines the Panel on Antiretroviral Guidelines for Adults and Adolescents (the Panels') recommendation on the frequency of testing. As noted in the table, some tests may be repeated more frequently if clinically indicated."

Pediatric guidelines: "Frequent patient visits and intensive follow-up during the initial months after a new antiretroviral (ART) regimen is started are necessary to support and educate the family… "Within 1 to 2 weeks of initiating therapy, children should be evaluated either in person or by phone to identify clinical AEs and to support adherence. Many clinicians plan additional contacts (in person, by telephone, or via email) with children and caregivers to support adherence during the first few weeks of therapy." "After the initial phase of ART initiation, regimen adherence, effectiveness (CD4 cell count and plasma viral load), and toxicities (history, physical and laboratory testing) should be assessed every 3 to 4 months in children receiving ART. Some experts monitor CD4 cell count less frequently (e.g., every 6 to 12 months) in children and adolescents who are adherent to therapy and have CD4 cell count values well above the threshold for OI risk, sustained viral suppression, and stable clinical status for more than 2 to 3 years."

Gap in HIV Medical Visits

Description: Percentage of patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year

Numerator: Number of patients in the denominator who did not have a medical visit in the last 6 months of the measurement year

Denominator: Number of patients, regardless of age with a diagnosis or HIV who had at least one medical visit in the first 6 months of the measurement year

Patient Exclusions: Patients who died at any time during the measurement year

Data Elements: Does the patient, regardless of age, have a diagnosis of HIV? (Y/N) a. If yes, did the patient have at least one medical visit in the first 6 months of the measurement year? (Y/N) i. If yes, did the patient have one or more medical visits in the last 6 months of the measurement year.

Adult guidelines: "A number of laboratory tests are important for initial evaluation of HIV-infected patients upon entry into care, during follow-up (if antiretroviral therapy (ART) has not been initiated), and before and after the initiation or modification of therapy to assess virologic and immunologic efficacy of ART and to monitor for laboratory abnormalities that may be associated with antiretroviral (ART) drugs. Table 3 outlines the Panel's recommendations for the frequency of testing. As noted in the table, some tests may be repeated more frequently if clinically indicated."

Pediatric guidelines: "Frequent patient visits and intensive follow-up during the initial months after a new antiretroviral (ART) regimen is started are necessary to support and educate the family…Thus, it is prudent for clinicians to assess children within 1 to 2 weeks of initiating therapy, either in person or with a phone call, to ensure that medications are being administered properly and evaluate clinical concerns. Many clinicians schedule additional contact (in person or over the telephone) with children and their caregivers during the first few weeks of therapy to support adherence…Thereafter, medication adherence and regimen toxicity and effectiveness should be assessed every 3 to 4 months in children taking ART drugs. Some experts monitor CD4 cell counts and HIV RNA levels less frequently in children and youth who are adherent to therapy and have sustained viral suppression and stable clinical status for more than 2 to 3 years."

Pneumocystis jirovecii Pneumonia (PCP) Prophylaxis

Description: Percentage of patients aged 6 weeks or older with a diagnosis if HIV/AIDS, who were prescribed Pneumocystis jirovecii pneumonia (PCP) prophylaxis *Use the numerator and denominator that reflect patient population

Numerator:

Numerator 1: Patients who were prescribed Pneumocystis jirovecii pneumonia (PCP)

prophylaxis within 3 months of CD4 count below 200 cells/mm3

Numerator 2: Patients who were prescribed Pneumocystis jirovecii pneumonia (PCP) prophylaxis within 3 months of CD4 count below 500 cells/mm or a CD4 percentage below 15%

Numerator 3: Patients who were prescribed Pneumocystis jirovecii pneumonia (PCP) prophylaxis at the time of HIV diagnosis

*Aggregate Numerator = The sum of the three numerators

Denominator:

Denominator 1: All patients aged 6 years and older with a diagnosis of HIV/AIDS and a CD4 count below 200 cells/mm , who had at least two visits during the measurement year, with at least 90 days in between each visit;

And

Denominator 2: All patients aged 1 through 5 years of age with a diagnosis of HIV/AIDS and a CD4 count below 500 cells/mm or a CD4 percentage below 15%, who had at least two visits during the measurement year, with at least 90 days in between each visit;

And

Denominator 3: All patients aged 6 weeks through 12 months with a diagnosis of HIV, who had at least two visits during the measurement year, with at least 90 days in between each visit

*Total Denominator = The sum of the three denominators

Patient Exclusions: Denominator 1 Exclusion: Patient did not receive PCP prophylaxis because there was a CD4 count above 200 cells/mm3 during the three months after a CD4 count below 200 cells/mm3

Denominator 2 Exclusion: Patient did not receive PCP prophylaxis because there was a CD4 count above 500 cells/mm3 or CD4 percentage above 15% during the three months after a CD4 count below 500 cells/mm3 or CD4 percentage below 15% Data Elements:

Numerator/Denominator 1: 1. Is the patient 6 years or older and have a diagnosis of HIV?

(Y/N)

a. If yes, did the patient have at least two medical visits in the measurement year with at least 90 days between visits? (Y/N)

If yes, did the patient have a CD4 count < 200 cells/mm3? (Y/N)

If yes, was PCP prophylaxis prescribed within 3 months of CD4< 15% within the first 9 months of the measurement year? (Y/N)

If yes, was PCP prophylaxis prescribed within 3 months of CD4< 15%? (Y/N)

If yes, was PCP prophylaxis prescribed within 3 months of CD4 count < 15%? (Y/N)

Numerator/Denominator 3: Is the patient between 6 weeks and 12 months old and have a diagnosis of HIV? (Y/N)

a. If yes, did the patient have at least two medical visits in the measurement year with at least 90 days between visits? (Y/N)

If yes, was PCP prophylaxis prescribed at HIV diagnosis?

***Greater measure specification detail is available including data elements for each value set

Adult guidelines: "HIV-infected adults and adolescents, including pregnant women and those on ART, should receive chemoprophylaxis against PCP if they have CD4 counts <200 cells/mm3 (AI). Persons who have a CD4 cell percentage of <14% should also be considered for prophylaxis (BII). Initiation of chemoprophylaxis at CD4 counts between 200 and 250 cells/mm3 also should be considered when starting ART must be delayed and frequent monitoring of CD4 counts, such as every 3 months, is impossible (BII). Patients receiving pyrimethamine-sulfadiazine for treatment or suppression of toxoplasmosis do not require additional prophylaxis for PCP (AII)."

Pediatric guidelines: "Chemoprophylaxis is highly effective in preventing PCP. Prophylaxis is recommended for all HIV-Infected children aged ≥ 6years who have a CD4 T lymphocyte (CD4) counts <200 cells/mm3 or CD4 percentage <15% for children aged 1 to <6years with CD4 counts <500 cells/mm3 or CD4 percentage <15%, and for all infants aged <12 months regardless of CD4 count or percentage. Infants born to mothers living with HIV should be considered for prophylaxis beginning at 4–6 weeks of age. Infants born to mothers living with HIV should be administered prophylaxis until 1 year of age, at which time they should be reassessed on the basis of the age-specific CD4 count or percentage thresholds mentioned above (AII)."

Annual Retention in Care

Description: Percentage of patients, regardless of age, with a diagnosis of HIV who had at least two (2) encounters within the 12-month measurement year.

Numerator: Number of patients in the denominator who had at least two HIV medical care encounters at least 90 days apart within a 12-month measurement year. At least one of the two HIV medical care encounters needs to be a medical visit with a provider with prescribing

privileges.

Denominator: Number of patients, regardless of age, with a diagnosis of HIV who had at least one HIV medical encounter within the 12-month measurement year.

An HIV medical care encounter is a medical visit with a provider with prescribing privileges or an HIV viral load test.

Patients Exclusions: Patients who died at any time during the measurement year.

Data Elements: Does the patient, regardless of age, have a diagnosis of HIV? (Y/N)

a. If yes, did the patient have at least two medical care encounters during the measurement year? (Y/N)

i. If yes, did the patient have a HIV viral load test within the measurement year? (Y/N)

ii. If yes, did the patient have at least one additional medical visit encounter with a provider with prescribing privileges within the measurement year? (Y/N)

iii. Or, did the patient have two medical visit with provider with prescribing privileges within the measurement year? (Y/N)

Adolescent/Adult Guidelines: "Several laboratory tests are important for initial evaluation of patients with HIV upon entry into care, and some tests should be performed before and after initiation or modification of antiretroviral therapy (ART) to assess the virologic and immunologic efficacy of ART and to monitor for laboratory abnormalities that may be associated with antiretroviral (ART) drugs. Table 3 outlines the Panel on Antiretroviral Guidelines for Adults and Adolescents (the Panel)'s recommendations on the frequency of testing. As noted in the table, some tests may be repeated more frequently if clinically indicated.

Additionally, Table 3. Laboratory Testing Schedule for Monitoring Patients with HIV Before and After Initiation of Antiretroviral Therapy indicates viral load test should be performed at entry into care; ART initiation or modification; two to eight weeks after ART initiation or modification; in patients on ART every three to six months; every six months of the patient for patients adherent with consistently suppressed viral load and stable immunologic status for more than two years; treatment failure; clinically indicated; and if ART initiation is delayed.

Pediatric Guidelines: "After the initial phase of ART initiation (1 month–3 months), 2 clinicians should assess a patient's adherence to the regimen and the regimen's effectiveness (as measured by CD4 cell count and plasma viral load) every 3 months to 4 months. Additionally, clinicians should review a patient's history of toxicities and evaluate a patient for any new AEs using physical examinations and the relevant laboratory tests. If laboratory evidence of toxicity is identified, testing should be performed more frequently until the toxicity resolves."

The Panel on Antiretroviral Therapy and Medical Management of Children Living with HIV

finds value in continuing to perform viral load testing every 3 to 4 months to provide enhanced monitoring of adherence or disease progression among children and adolescents. Some experts monitor CD4 cell count less frequently (e.g., every 6 months to 12 months) in children and adolescents who are adherent to therapy, who have CD4 cell count values well above the threshold for OI risk, and who have had sustained virologic suppression and stable clinical status for >2 years to 3 years. Some clinicians find value in scheduling visits every 3 months even when lab testing is not performed, in order to review adherence and update drug doses for interim growth

Additionally, Sample Schedule for Clinical and Laboratory Monitoring of Children Before and After Initiation of Antiretroviral Therapy indicates viral load tests should be performed at entry into care; pre-therapy; ART initiation; weeks two to four on therapy, every three to four months to monitor ART adherence; and when switching ART regimens.

STANDARD X: PERSONNEL QUALIFICATIONS

At minimum, all OAHS services staff will be able to provide linguistically and culturally age-appropriate care to people living with HIV and complete documentation as required by their positions. Staff will complete an agency-based orientation before providing services. All new staff must receive HIV/AIDS education within the first three months of employment. Staff will also be trained and oriented regarding patient confidentiality and HIPAA regulations. In addition, staff will be provided with ongoing, consistent supervision that addresses clinical, administrative, psychosocial, developmental, and programmatic issues on a monthly basis. Programs will develop personnel policies and procedures that require and support the continuing education of all HIV/AIDS health care professionals.

Programs are expected to budget costs for HIV/AIDS continuing education specifically in HIV prevention and disease management, to purchase practice guidelines in formats easily accessible and usable for practitioners, and to provide practitioners routine access to computerized educational and prevention/care treatment problem solving (e.g., The Body at https://www.thebodypro.com/; HIV InSite at http://hivinsite.ucsf.edu/
Johns Hopkins AIDS Service at https://www.hopkinsmedicine.org/health/conditions-and-diseases/hiv-and-aids or, Medline Plus – AIDS at https://medlineplus.gov/hivaidsandinfections.html and many others.

Programs will develop consultation protocols to assist OAHS health care professionals seeking expert advice and consultation whenever needed. Seeking expert advice and using the many local or regional university-based consultation services is evidence of competent prevention and disease management. All OAHS providers are expected to practice in accordance with applicable state and federal regulations, statutes and laws. OAHS practitioners must comply with codes of ethics and with any special HIV/AIDS policies from their respective national professional associations. Clinicians can consult clinical HIV experts at the National Clinician Consultation Center at https://nccc.ucsf.edu/

HIV OAHS services will be provided by a multidisciplinary team consisting of a primary care provider at the level of the jurisdictions of practice DC, Maryland, Virginia and West Virginia, Licensed physician, NP, and/or PA and an RN. The expanded team should include a medical care coordination staff, registered dietitian, health educator, treatment educator/advocate, and other ancillary support service providers for formal coordination of these services.

Standards	Elements	Measures
OAHS staff will be able to provide linguistically and culturally age-appropriate care and complete documentation as required by their positions.		Resumes and record of training in employee file to verify.
Staff will receive an agency orientation, HIV training within three months of employment and oriented and trained in confidentiality and HIPAA compliance		Record of orientation and training in employee file.
Staff will receive consistent supervision in clinical, administrative, psychosocial, developmental and programmatic issues on a monthly basis.		Supervision record on file at provider agency
Programs will budget costs for HIV/AIDS continuing Education		Budget review to confirm.
Programs will develop consultation protocols		Consultation protocols on file at provider agency.
OAHS providers are expected to practice in accordance with state and federal regulations, statutes and laws, as well as codes of ethics and with any special HIV/ AIDS policies from their respective national professional associations.		Program review and monitoring to confirm

HEALTH CARE PROFESSIONALS SERVICES

The following categories of health care professionals are approved to provide medical services in OAHS care programs:

- Physician (MD or DO) who is an HIV/AIDS specialist
- NP who is an HIV/AIDS specialist
- PA who is an HIV/AIDS specialist

RNs and licensed practical/vocational nurses (LPN/LVNs) may provide primary HIV nursing care services and medical care coordination.

STAFF QUALIFICATIONS

Agencies requesting funding to provide OAHS services must employ, contract with, or refer to professionals with the following qualifications:

◆ **Physician HIV Specialist**:

A physician (MD or DO) providing OAHS services must hold a valid license to practice medicine in the District of Columbia, states of Maryland, Virginia and/or West Virginia and must either be credentialed as an HIV/AIDS Specialist by the American Academy of HIV Medicine, or must meet the following criteria:
In the immediately preceding 24 months,

- has provided continuous and direct medical care consistent with current HHS Guidelines with peer review and supervision to a minimum of 20 patients who are infected with HIV,

and

Has completed any one of the following:

- In the immediately preceding 12 months has obtained board certification or recertification in the field of infectious diseases
- In the immediately preceding 12 months has successfully completed a minimum of 30 hours of "Category 1 Continuing Medical Education" in the prevention, diagnosis, and treatment of HIV-infected patients
- In the immediately preceding 12 months has successfully completed a minimum of 15 hours of "Category 1 Continuing Medical Education" in the prevention, diagnosis, and treatment of HIV-infected patients and successfully completed the "HIV Medicine Competency Maintenance Examination" administered by the American Academy of HIV Medicine (www.aahivm.org)
- Has a credible plan to complete Infectious Diseases fellowship or HIV/AIDS specialist criteria within one year
- Is in a fellowship or other training program under the supervision of a physician who meets these criteria

◆ **NP HIV/AIDS Specialist:**

An NP providing OAHS services must have the following qualifications:

• Licensure as an RN
• An NP certificate or master's degree from a school accredited by the various Board of Registered Nursing in the DC EMA
• A credential as an HIV/AIDS specialist by the American Academy of HIV Medicine (www.aahivm.org) or have a credible plan to complete HIV/AIDS specialist criteria within one year.

NPs are permitted to practice independently in the District of Columbia, Maryland, Virginia, and West Virginia (DC NP regulations).

Programs will develop, implement and maintain standardized procedures for all medical functions to be performed by the NP using the Guidelines for Developing Standardized Procedures produced by the jurisdiction of practice. The NP must work within the scope of practice defined by Code of Regulations in the jurisdiction of practice.

◆ PA HIV/AIDS Specialist:

A PA providing OAHS services must have graduated from a medical training program approved by the jurisdiction of practice and must have passed the Physician Assistant National Certifying Examination (PANCE) offered by the National Commission on Certification of Physician Assistants (NCCPA). PAs must be licensed in the jurisdiction of practice and must be credentialed as an HIV/AIDS specialist by the American Academy of HIV Medicine (www.aahivm.org) or have a credible plan to complete HIV/AIDS specialist criteria within one year. The PA works under the direct supervision of an HIV/AIDS specialist physician. Physician supervision must include regular chart review, as well as oversight of scheduled direct patient care. For regulations specifying physician accountabilities, supervision requirements and a description of a PA's scope of practice in the different jurisdiction in the DC EMA, refer to the different jurisdictions regulations (DC PA regulations) Delegation of Services Agreement between the supervising physician and PA must specify HIV/AIDS medical services delegated to the PA and must be available for review. PAs authorized by supervising physicians to issue written "drug orders" for medication and medical devices must do so in compliance with the laws of the jurisdiction of practice.

◆ Medical Specialists:

OAHS programs are responsible for recruiting medical specialists who have demonstrated experience in HIV/AIDS specialty/subspecialty care. Ideally, medical specialists will already be providing care for people living with HIV in their current practices and have the requisite training and certification in his or her respective medical specialty or subspecialty. Medical specialists must maintain their licenses by fulfilling the continuing education requirements established by their respective professional state and national boards. Additionally, medical specialists must be board-certified or board-eligible in their specialty. OAHS programs are encouraged to pass along educational opportunities and materials to their contracted specialists to improve their HIV knowledge and expertise. All medical specialists are expected to practice in accordance with applicable state and federal regulations, statutes and laws. Medical specialists must comply with codes of ethics and with any special HIV/AIDS policies from their respective national professional associations.

◆ A Register Nurse (RN):
An RN providing OAHS services must hold a license in good standing from the jurisdiction of practice, District of Columbia, Maryland, Virginia and West Virginia. Registered Nurses must be a graduate from an accredited nursing program with a Bachelor of Science in Nursing (BSN) or two-year nursing associate degree. Prior to employment, a BSN must have experience providing direct care to HIV-infected individuals, and an RN with an associate degree must have practiced one year in an HIV/AIDS clinic setting providing direct care to HIV-positive patients (see: Association of Nurses in AIDS Care www.anacnet.org). The RN must practice within the scope of practice defined in the jurisdiction of practice

Standards	Elements	Measures
Physicians (MD or DO) providing OAHS services hold License in the jurisdiction of practice and be credentialed as an HIV/AIDS specialist, have a credible plan to complete HIV/AIDS specialist criteria within one year or meet strict experience criteria		Resumes and verification of specialist or experience criteria on file at provider agency.
NP HIV/AIDS specialists practitioners providing OAHS services must hold: • Licensure as an RN • NP certificate or master's degree from an accredited school • Credential as an HIV/AIDS specialist or credible plan to complete credential in one year		Resumes and verification of specialist and experience criteria on file at provider agency
NPs prescribing medications must hold a DEA license.		Practitioner furnishing certificates on file at provider agency.
NPs must work within the scope of practice defined by the laws in the different jurisdictions of practice; District of Columbia, Maryland, Virginia and West Virginia		Program review and monitoring to confirm
PAs providing OAHS must have: • Graduated from an approved medical training program • Passed the Physician Assistant National Certifying Examination (PANCE)		Record of physician supervision on file at provider Agency Resumes and verification of specialist

Standards	Elements	Measures
A license from the Physician Assistant Committee (DC) and other equivalent for other jurisdictions if applicable. • A credential as an HIV/AIDS specialist, or have a credible plan to complete credential in one year . PAs must be supervised by an HIV/AIDS specialist Physician, including chart review and oversight of scheduled direct patient care.		and experience criteria on file at provider agency
PAs issuing drug orders must do so in compliance with the laws of the jurisdiction of practice.		Program review and monitoring to confirm.
It is preferred that medical specialists will have demonstrated experience in HIV specialty care, including providing care to people living with HIV in current practice		Documentation of experience on file at provider agency.
Medical specialists must maintain licenses and requirements established by their respective professional state and national boards and will be board-certified or board-eligible in their specialty		Specialists licenses and board status documentation on file at provider agency.
Medical specialists are expected to practice in accordance with state and federal regulations, statutes, and laws, as well as codes of ethics and with any special HIV/AIDS policies from their respective national professional associations.		Program review and monitoring to confirm.
RNs providing OAHS services must: • Hold a license in good standing from the jurisdiction of practice • Be a graduate from an accredited nursing program with a BSN or two-year nursing associate degree • Have experience providing direct HIV care (BSNs) • Have practiced one year in an HIV/AIDS clinic setting providing direct care to HIV-positive patients (associate degrees) • Practice within the scope defined in the law and ethics of the profession		Resumes on file at provider agency to verify experience. Program review and monitoring to confirm

EDUCATION AND LICENSING

Staff employed to provide OAHS services must maintain licenses by fulfilling the financial and continuing education requirements established by their respective professional states and national boards. OAHS practitioners must comply with their jurisdictional requirements for continuing education recertification addressing HIV treatment adherence.

These requirements must be met annually for continued employment in the OAHS care program. In selecting other continuing education courses to fulfill licensing requirements, OAHS practitioners are encouraged to select a majority of courses related to their respective scopes of practice and courses related to services within the HIV/AIDS continuum's primary health care core.

Standards	Elements	Measures
OAHS staff must maintain licenses by completing continuing education requirements of their respective professional boards.		Record of continuing education in employee files at provider agency.
OAHS practitioners must complete annually: • One accredited HIV/AIDS treatment adherence course • One accredited HIV/AIDS clinical care management course • One accredited HIV/AIDS prevention, education, and risk reduction course		Record of continuing education in employee files at provider agency

APPROVAL & SIGNATURES

This service standard has been reviewed and approved on July 28, 2021. The next annual review is July 28, 2022.

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