N-S EMA OUTPATIENT AMBULATORY HEALTH SERVICE (OAHS) SERVICES STANDARD

Service standards outline the elements and expectations a RWHAP Service provider follows when implementing a specific service category. The purpose of service standards are to ensure that all RWHAP service providers offer the same fundamental components of the given service category across a service area. Service standards establish the minimal level of service or care that a RWHAP funded agency or provider may offer within a state, territory or jurisdiction.

N-S HIV Health Services Planning Council
www.longislandpc.org

Approved by Planning Council on 11/8/17

Outpatient Ambulatory Health Services (OAHS): Outpatient/Ambulatory Health Services are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight. ***Emergency room or urgent care services are not considered outpatient settings.***

Program Guidance: Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category whereas Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category.

Care and Treatment Goals: To provide eligible individuals with the provision of primary medical care for the treatment of HIV infection that is consistent with the U.S. Public Health Services Guidelines. OAHS must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. Outpatient Ambulatory Health Services will be provided in a culturally and linguistically appropriate manner to ensure maintenance in care and adherence to HIV medication regimens. Services target populations that are newly diagnosed/out of care, uninsured, underinsured, and disproportionately impacted by HIV/AIDS in the Nassau-Suffolk Eligible Metropolitan Area (EMA).

Program Components:

- Diagnostic testing
- Early intervention and risk assessment,
- Preventive care and screening
- Practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions
- Physical examination
- Prescription and management of medication therapy
- Education and counseling on health and prevention issues
- Well-baby care
- Continuing care and management of chronic conditions
- Referral to and provision of HIV-related specialty care (includes all medical subspecialties even ophthalmic and optometric services
- Provision of **laboratory tests** integral to the treatment of HIV infection and related complications
- Assessment and treatment of physical or behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Pediatric developmental assessment
- Treatment adherence

Program Outcomes:

- New/out of care HIV diagnosed clients are engaged/re-engaged in care
- Clients receiving Outpatient Ambulatory Health Services are on Antiretroviral Therapy (ART)
- Clients receiving Outpatient Ambulatory Health Services and on ART will achieve Viral Load Suppression (VLS) within six months of the initiation of ART

Indicators:

- Linkage and retention with OAHS provider as evidenced in client medical records/patient charts
- Medication list in client medical record/patient chart documenting ARV treatment protocol
- Lab results reflecting a viral load of less than 200 copies/mL

Service Units: Face to face individual level intervention in CAREWare:

- Intake/client eligibility: 30-45 minutes = 1 unit of service
- Initial HIV evaluation: 60-90 minutes = 1 unit of service
- Routine medical office visit: 45 minutes = 1 unit of service
- Specialty Care (Laboratory, colonoscopy, EKG, vaccinations, screenings): 1 unit of service
- Care Coordination: 1 unit of service
- Referrals: 1 unit of service
- Treatment Plan development /update: 1 unit of service

Program Data Reporting:

Part A service providers are responsible for documenting and keeping accurate records of Ryan White Program data and client information, units of service, and client health outcomes. Reporting units of service are a component of each agency's approved workplan. Please refer to the most current workplan, including any amendments, for guidance regarding units of service. Summaries of service statistics by priority will be made available to the Planning Council by the grantee for priority setting, resource allocation and evaluation purposes.

Client Level Data Reporting of Clinical Information

For Outpatient/Ambulatory Health Services clinical information data elements are collected in the client-level data XML file. Clinical information is required to be reported by all providers who received RWHAP funding to provide outpatient/ambulatory health services. Clinical information is required for HIV-positive clients who received an outpatient/ambulatory medical care visit in the provider's HIV care setting with a clinical care provider during the reporting period, regardless of the payer. Clinical information is not required to be reported for HIV-indeterminate (infants <2 years only) clients.

OAHS data is reported in CAREWare, client files or electronic health records. A full description of the client level data elements listed below for OAHS are included in the chart on page 15.

OAHS data elements:

- **Client received HIV risk-reduction screening/counseling**
- **Date of client's first HIV outpatient/ambulatory care visit**
- **Dates of the client's outpatient ambulatory care visits**
- **Client's CD4 Test**
- **Client's Viral Load Test**
- **Client prescribed PCP prophylaxis**
- **Client prescribed ART**
- **Client has been screened for TB since HIV diagnosis**
- **Client was screened for syphilis during this reporting period**
- **Client was screened for hepatitis B since HIV diagnosis**

- **Client has completed the vaccine series for hepatitis B**
- **Client screened for hepatitis C since HIV diagnosis**
- **Client was screened for substance use**
- **Client received mental health screening**
- **Client received a Pap Smear**
- **Client was pregnant**
- **Positive HIV Test Date**
- **OAHS Link Date**

HRSA Program Monitoring Standard

STANDARD	MEASURE
Program Components	
• Initial and Ongoing Assessment of Client Service Needs • Services provided in a culturally and linguistically competent manner. (The National Culturally and Linguistically Appropriate Standards [CLAS]) are being followed. • Development of Comprehensive and Individual Care or Treatment Plan with client • Coordination of services to implement Plan and assist client in maintenance in medical care • Services must be provided by licensed clinical staff knowledgeable about available resources, HIV/AIDS and evidenced based substance abuse treatment modalities and reimbursement models.	• **Documentation of Eligibility** including proof of HIV+ status, Insurance status, Residency-Nassau or Suffolk County, and Income up to 435% of Federal Poverty Level (FPL) • Documentation of Assessment of Client Service Needs (including access to other resources, payer sources, presenting problem, relevant history, Care or Service Plan including basic medical history, substance use disorder, mental health status, medications, etc.) • Documented Treatment Plan (date of development, problems to be addressed, interventions addressing goals, planned frequency of contact, start and end date of treatment, staff and client signature) • Documentation of services determined needed and coordination • Documentation that progress is occurring through reassessments every 6 months • Documentation of licensure and training specific to HIV/AIDS • Assessment and documentation of language, cultural or other barriers and ways to reduce barriers

OUTCOME	MEASURE
Increase the amount of HIV+ clients retained in care.	**90%** of clients will have at least two primary HIV medical care visits within 12 months. Visits shall be ***at least*** 60 days apart within the 12 month period.
Increase the amount of HIV/AIDS clients that are virally suppressed.	**85%** of clients receiving OAHS will achieve Viral Load Suppression (*as measured by the last viral load test during the measurement year).*
Increase the number of HIV/AIDS clients on antiretroviral medications.	**100%** of clients will be **prescribed** HIV antiretroviral medications.

PERSONNEL:

Staff Qualification	Expected Practice
Agency staff are trained and knowledgeable about primary medical care, HIV disease and treatment and available resources that promote the continuity of client care.	Personnel records/resumes/applications for employment reflect requisite experience/education.
Agency will ensure that all staff, inclusive of, but not limited to, physicians, physicians' assistants, nurse practitioners, registered nurses, licensed practical nurses, medical assistants and peers providing primary care or assisting in the provision of primary care are licensed/certified to practice within their concentrated area consistent with New York State Law.	Current License/Certification will be maintained on file.
Agency staff will receive supervision, training, and continual education as required by licensure/certification. In addition, clinical staff (including physicians, physicians' assistants, nurse practitioners, pharmacists, and nurses) will receive a minimum of 10 continuing education hours per year in HIV/AIDS specialty course work	Documentation of training on file.
Trainings in cultural competency, with specific focus on minorities, non-English speakers, LGBTQ, Transgender, HIV confidentiality and at least 1-2 HIV specific trainings annually.	Documentation of training on file.
Agency staff will follow protocols on management of occupational exposure to HIV consistent with the latest version of the federal guidelines. Staff will also adhere to state public health practices for infection control.	Documentation on file.

Client Verification of Eligibility:
As required by HRSA/HAB Policy Notice #13-02. Ryan White Eligibility and proof of documentation are required at intake/assessment and must be updated every 6 months. Please refer to the N-S EMA's Ryan White Client Eligibility Guidelines for specific information and acceptable forms of documentation.

Standard	Provider/Sub-grantee Responsibility
Client Eligibility determination for Ryan White services within a predetermined timeframe	**Initial Eligibility Determination Documentation Requirements:** • HIV/AIDS Diagnosis (at initial determination); • Proof of residence (Nassau or Suffolk); • Proof of Income <435% of the Federal Poverty Level; • Proof of Insurance Status- Uninsured or underinsured status (insurance verification as proof); • Determination of eligibility and enrollment in other third party insurance programs including Medicaid, Medicare; • For underinsured, proof this service is not covered by other third party insurance programs including Medicaid and Medicare;
Determination of program eligibility for enrollment in Ryan White Part A services based on a diagnosis of HIV/AIDS.	Documentation in client file of diagnosis of HIV/AIDS, including copy of lab report, detectable viral load, certified letter from physician, or copy of Western Blot Assay.
Reassessment of clients at least every 6 months to determine continued eligibility	**Reassessment (minimum of every six months) documentation requirements**: • Proof of residence; • Low income documentation; • Uninsured or underinsured status (insurance verification as proof); • Determination of current or new eligibility and enrollment in other third party insurance programs including Medicaid and Medicare; • Document that the process and timelines for establishing initial client eligibility, assessment, and recertification takes place at a minimum every six months; • Document that all staff involved in eligibility determination have participated in required training; • Sub-grantee client data reports are consistent with eligibility requirements specified by funder, which demonstrates eligible clients are receiving allowable services. **Note:** Full documentation must be provided and placed in the client file at least once per year. At the six month reassessment providers may use a signed client checklist to show eligibility review and no change. If any change has occurred, proof of new documents must be collected and placed in client file.

Standard	*Outcome Measure*	*Numerator*	*Denominator*	*Data Source*	*Goal/Benchmark*
INTAKES					
Upon initial contact with a client, agency will assess client for emergent or routine medical care according to agency policies and procedures. Clients with urgent medical needs shall be referred to an emergency care facility in accordance with agency policies and procedures.	Documentation in client's file demonstrating assessment of initial medical care need.	Number of clients assessed for either emergent or routine medical care.	Number of clients referred for Outpatient Ambulatory Health Services	Client Files CAREWare	100% of clients will be assessed for emergent or routine medical care upon initial contact with provider
Clients in need of routine medical care will be scheduled to be seen for an initial appointment within 10 days from the eligibility verification date.	Documentation in client's file that client was seen for an initial medical appointment within 10 days from the eligibility verification date.	Number of clients seen for an initial medical appointment within 10 days from the eligibility verification date	Number of new clients accessing Outpatient Ambulatory Health Services	Client Files CAREWare	90% of new clients in need of routine medical care will be scheduled to be seen for an initial appointment within 10 days from the eligibility verification date
Eligibility					
Client eligibility will initially be determined upon first contact and will be reassessed every six months. Eligibility assessment must include at a minimum: 1) Proof of insurance 2) Proof of HIV status 3) Proof of income < 435% of the Federal Poverty Guidelines 4) Proof of residency within the Nassau-Suffolk EMA	Documentation in client's file that they were assessed for RWA eligibility. This can include a checklist, summary, progress note, etc. Back up proof of eligibility must be present, and may include: Photo ID, proof of address, copies of paystubs, SSI/D award letter, and proof of insurance.	Number of clients assessed for RWA eligibility	Number of new clients accessing Outpatient Ambulatory Health Services	Client Files	100% of new clients will be assessed for eligibility for services under Part A of the Ryan White CARE Act

Standard	*Outcome Measure*	*Numerator*	*Denominator*	*Data Source*	*Goal/Benchmark*
Clients will receive standardized screening for: medical case management, mental health, substance abuse, and legal needs during a face to face contact from program staff during eligibility determination.	Documentation in client's chart that they were screened/assessed for medical case management, mental health, substance abuse, and legal needs	Number of clients that received face-to-face screening for OAHS	Number of new clients requesting OAHS	Client Files	100% of new clients will be screened for medical case management, mental health, substance abuse, and legal needs during face-to-face contact with staff
ASSESSMENT					
A) Clients will have a comprehensive initial intake and assessment which will be completed within the first two primary care visits scheduled with the primary care provider. The initial assessment shall include, but is not limited to the following: 1) Chief complaint 2) Immunization status 3) Past medical and surgical history with detailed HIV/AIDS history 4) Family and social history including substance abuse and mental health histories 5) Allergies to medications 6) Current medications 7) Current nutrition including supplements 8) Any present illnesses or concerns 9) Screening for diseases associated with risk factors (Hepatitis A, Hepatitis B, Hepatitis C, TB and Sexually	Documentation of intake/assessment in client's chart inclusive of all areas indicated in the aforementioned standard.	Number of clients that received intake/assessment within the first two primary care visits	Number of new clients receiving OAHS	Client Files CAREWare	90% of new clients will have an intake/assessment conducted within the first two primary care visits scheduled with provider

Standard	*Outcome Measure*	*Numerator*	*Denominator*	*Data Source*	*Goal/Benchmark*
Transmitted Infections)					
Initial assessments will include a comprehensive physical examination in accordance with the most current published guidelines for the Use of Antiretroviral Agents in HIV Infected Adults and Adolescents (USPHS Guidelines). The physical examination shall include, but is not limited to the following: 1) Vital signs 2) Systems inspection, inclusive of a dermatological examination 3) Neurological examination 4) Genital and rectal exams as appropriate 5) Breast examination as appropriate	Documentation of a comprehensive physical exam in client's chart in accordance with USPHS Guidelines.	Number of clients receiving a comprehensive physical exam	Number of new clients receiving OAHS	Client Files	90% of new clients will receive a comprehensive physical examination in accordance with the most current published HAB/HRSA guidelines
Appropriate baseline testing, including laboratory and radiology values, will be performed within the first two primary care visits scheduled with the primary care provider. Tests shall be inclusive of, but not limited to the following: 1) Complete Blood Count (CBC) 2) Toxoplasmosis serology (unless previously positive) 3) Chemistry profile, including serum transaminases and lipid profile 4) Urinalysis	Documentation of all indicated baseline laboratory and radiology values within the client's chart.	Number of clients receiving all indicated baseline testing within the first two primary care visits.	Number of new clients receiving OAHS	Client Files CAREWare	90% of new clients will receive all indicated baseline testing within the first two primary care visits

Standard	*Outcome Measure*	*Numerator*	*Denominator*	*Data Source*	*Goal/Benchmark*
5) STI Screening 6) CD4+ lymphocyte count 7) Viral load measurement 8) For patients with pretreatment HIV RNA >1,000 copies/mL – genotypic resistance testing prior to initiation of therapy; if therapy is to be deferred, resistance testing may still be considered 9) PAP smear for women and adolescent females 10) Routine assessments for Opportunistic Infections 11) TB and/or chest x-ray if indicated 12)Electrocardiogram if over 40 or otherwise indicated					
Referrals to specialists (e.g. dentists, ophthalmologists) to be provided if indicated, including nutritional services as appropriate.	Documentation of all referrals to specialists indicated by provider in client chart	Number of clients that received referrals to specialists as indicated by provider	Number of clients identified as needing a referral for specialty care.	Client Files CAREWare	90% of all indicated clients will receive a referral for specialty care
TREATMENT PLANS					
Providers shall, in conjunction with the client, develop a comprehensive multi-disciplinary plan of care that will be reviewed and updated as conditions warrant or at a minimum of every six months	Documentation of a comprehensive plan of care in client's chart	Number of clients with a comprehensive plan of care	Number of clients receiving OAHS	Client Files CAREWare	85% of clients accessing OAHS will have a comprehensive plan of care which will be updated every six months

Standard	*Outcome Measure*	*Numerator*	*Denominator*	*Data Source*	*Goal/Benchmark*
Providers shall develop and initiate a client treatment adherence plan for clients who are being treated with an antiretroviral (ARV) medication regimen. At a minimum of every 6 months.	Documentation of a treatment adherence plan in client's chart	Number of clients with a treatment adherence plan	Number of clients receiving OAHS	Client Files	85% of clients accessing OAHS will have a treatment adherence plan
Health Maintenance					
Client medical record will contain an up to date profile which identifies at a minimum: 1) HIV status/AIDS diagnosis 2) History of mental health and substance use disorders 3) Contact information for ancillary continuing health care (e.g. mental health or substance abuse service provider, OB/GYN or other continuing specialty service) 4) The status of vaccinations 5) Any and all known allergies	Documentation of profile in client's chart which supports the need for primary care management	Number of clients with up to date profile	Number of clients receiving OAHS	Client Files	100% of clients will have an up to date profile completed and charted
Each client shall have a primary care visit scheduled at least every four months or as appropriate for current health status in accordance with the HAB/HRSA Standards. Clients must be seen every six months in order to be considered to be active in primary care.	Documentation of primary care visits in client chart	Number of clients that who have received primary care at least every four months or as appropriate.	Number of clients receiving OAHS	Client Files CAREWare	85% of clients will receive a primary care visit scheduled at least every four months or as appropriate for current health status in accordance with the USPHS Guidelines

Standard	*Outcome Measure*	*Numerator*	*Denominator*	*Data Source*	*Goal/Benchmark*
Each client shall have their CD4+ lymphocyte counts evaluated at least twice during the measurement year, accordance with the HAB/HRSA guidelines. These results shall be reviewed with the client at medical visits. Clients must be seen every six months in order to be considered to be active in primary care.	Documentation of CD4 lymphocyte count retained in client chart.	Number of active clients that have their CD4 lymphocyte count evaluated at least twice during the measurement year, or as appropriate for health status according to HAB/HRSA guidelines.	Number of clients accessing OAHS	Client Files CAREWare	90% of active clients will have their CD4 lymphocyte count evaluated at least twice during the measurement year, or as appropriate for health status according to HAB/HRSA guidelines
Each client shall have their viral load measurements evaluated at least twice during the measurement year in accordance with the HAB/HRSA guidelines. These results shall be reviewed with the client at medical visits. Clients must be seen every six months in order to be considered to be active in primary care.	Documentation of viral load measurements retained in client chart.	Number of active clients that have their viral load measurements evaluated at least twice during the measurement year, or as appropriate for health status according to HAB/HRSA guidelines.	Number of clients accessing OAHS	Client Files CAREWare	90% of active clients will have their viral load measurements evaluated at least twice during the m measurement year, or as appropriate for current health status according to HAB/HRSA guidelines
Clients will be assessed for Opportunistic Infections (OI) at each primary care visit in accordance with HAB/HRSA guidelines.	Documentation of OI assessment at each primary care visit within client chart	Number of clients assessed for OI's at each primary care visit.	Number of clients accessing OAHS	Client Files CAREWare	100% of all clients will be assessed for OI's at each primary care visit
OI Prophylaxis will be offered if clinically medicated.	Documentation of OI prophylaxis in client chart.	# given of OI prophylaxis.	# of clinically medicated clients.	Client files CareWare.	100% of clinically medicated clients will be offered OI prophylaxis

Standard	*Outcome Measure*	*Numerator*	*Denominator*	*Data Source*	*Goal/Benchmark*
Clients will have a TB screening annually in accordance with the HAB/HRSA Guidelines.	Documentation of an annual TB screening and or proof of prior treatment in client chart	Number of clients with a TB screening conducted annually	Number of clients accessing OAHS	Client Files CAREWare	100% of all eligible clients will have a TB screening conducted annually
Clients will receive timely and appropriate immunizations in accordance with HAB/HRSA guidelines:1) Pneumococcal pneumonia and then repeat once at five years 2) Tetanus every 10 years or as medically indicated 3) One time Tetanus, Diphtheria and Acellular Pertussis (TDAP) vaccine 4) Hepatitis A or B vaccine if indicated per ACIP guidelines 5) Prevnar pneumococcal vaccine (1/lifetime) If a client is not immunized, appropriate documentation will be included in the primary medical care chart.	Documentation of timely and appropriate immunizations in client chart.	Number of clients with all indicated vaccines conducted as per HAB/HRSA guidelines.	Number of clients accessing OAHS.	Client Files	90% of all clients will receive timely and appropriate immunizations in accordance with HAB/HRSA guidelines
Clients will receive timely and appropriate immunizations in accordance with HAB/HRSA guidelines:1) Influenza annually 2) HPV vaccine per ACIP guidelines or IDSA guidelines.	Documentation of timely and appropriate immunizations in client chart.	Number of clients with all indicated vaccines conducted as per HAB/HRSA guidelines.	Number of clients accessing OAHS.	Client files	90% of all clients will receive timely and appropriate immunizations in accordance with HAB/HRSA guidelines

Standard	*Outcome Measure*	*Numerator*	*Denominator*	*Data Source*	*Goal/Benchmark*
Clients will be assessed for educational, nutritional and psychosocial needs. Appropriate referrals will be made as needed in accordance with the Nassau-Suffolk EMA service standards. Issues to be discussed include, but are not limited to the following: 1) New or ongoing substance abuse or mental health issues 2) Housing status 3) Risk behaviors	Documentation of educational, nutritional, and psychosocial assessment needs retained in client chart.	Number of clients with a completed nutritional, educational, and psychosocial needs assessment	Number of clients accessing OAHS	Client Files CAREWare	90% of clients with a completed nutritional, educational, and psychosocial needs assessment, inclusive of substance abuse, mental health needs, housing concerns and risk behaviors
Provider shall screen sexually active clients for sexually transmitted infections annually in accordance with the HAB/HRSA guidelines. Clients at high risk shall be screened at least every six months. If clients have been screened at another facility, the client's primary medical care chart shall contain copies of the appropriate documentation	Documentation of STI screening in client chart. High risk clients will be screened every six months.	Number of clients screened for STIs in accordance with HAB/HRSA guidelines.	Number of clients accessing OAHS.	Client Files CAREWare	100% of clients will be screened for sexually transmitted infections annually in accordance with the HAB/HRSA guidelines
Providers shall assess client behaviors and offer/refer clients for lifestyle education/counseling regarding such areas as exercise, smoking cessation, risk reduction and safer sex practices.	Documentation of risk behavior assessment retained in client chart	Number of clients assessed for risk behaviors and referred for counseling services as indicated	Number of clients accessing OAHS	Client Files	90% of clients will be assessed for risk behaviors and referred for counseling services as indicated

Standard	*Outcome Measure*	*Numerator*	*Denominator*	*Data Source*	*Goal/Benchmark*
Providers will deliver primary medical care for the treatment of HIV infected pregnant women in a manner consistent with the HAB/HRSA recommended protocol or a referral to the appropriate agency will be provided to clients.	Documentation of primary medical care for pregnant female clients in accordance with the HAB/HRSA standards protocol	Number of pregnant women receiving primary medical treatment as per the USPHS standard protocol	Number of pregnant women receiving OAHS	Client Files	100% of pregnant women will receive primary medical treatment as per the USPHS standard protocol
Providers will deliver primary medical care for the treatment of HIV-infected pediatric clients in a manner consistent with the USPHS recommended protocol or a referral to the appropriate agency will be provided to clients.	Documentation of primary medical care for pediatric clients in accordance with the USPHS standards protocol	Number of pediatric clients receiving primary medical treatment as per the USPHS standard protocol	Number of pediatric clients receiving OAHS	Client Files	100% of pediatric clients will receive primary medical treatment as per the USPHS standard protocol
Providers shall offer or refer clients according to health maintenance screenings (e.g. mammograms, PAP Tests, prostate exams, hormone replacement therapy, gender affirming surgery) specific to their individual needs.	Documentation of health maintenance screening or referral in client chart	Number of clients with health maintenance screening conducted	Number of clients receiving OAHS	Client Files	100% of clients (with regard to age and gender identity) will have a health maintenance screening conducted as needed
Providers shall offer clients not currently on antiretroviral therapy (ART), who qualify for ARV treatment by DHHS guidelines, education and counseling on the risks and benefits of antiretroviral therapy at least twice per year.	Documentation of education and counseling in client chart on the benefits of antiretroviral therapy (ART)	Number of clients not currently on ARV offered education and counseling on the risks and benefits of antiretroviral therapy (ART)	Number of clients receiving OAHS that are not on ARV	Client Files CAREWare	100% of clients who are not currently on ARV are being offered education and counseling on the risks and benefits of antiretroviral therapy (ART) at least twice a year.

Standard	*Outcome Measure*	*Numerator*	*Denominator*	*Data Source*	*Goal/Benchmark*
Providers shall monitor antiretroviral therapy (ART) in accordance with HAB/HRSA guidelines inclusive of resistance testing when appropriate.	Documentation of ARV monitoring in client chart	Number of clients that have their antiretroviral therapy (ART) monitored in accordance with HAB/HRSA guidelines, inclusive of resistance testing	Number of clients accessing OAHS who are receiving ARV	Client Files	100% of OAHS clients on ARV will have their therapy monitored in accordance with HAB/HRSA guidelines
Discharge/Case Closure					
Agency will complete a case closure summary form, including level of care previously provided, outreach efforts, reasons for case closure and referrals made.	Documentation of completed discharge checklist retained in client chart	Number of clients with complete case closure summary	Number of clients who have case closed	Client Files CAREWare	100% of clients who had their case closed will have a case closure form

Data Reporting / Client Level Data Chart

Client received HIV risk-reduction screening/counseling	**XML Variable Name:** RiskScreeningProvidedID
Description: Indicate (yes/no) if HIV risk-reduction screening and/or counseling was provided to the client during this reporting period. HIV risk-reduction screening and counseling refers to a short questionnaire administered by a clinician to identify patients at risk for HIV infection or reinfection, followed by counseling of patients about ways to reduce their risk.	
Date of client's first HIV outpatient/ambulatory care visit	**XML Variable Name:** FirstAmbulatoryCareDateID
Description: Report the date of the client's first HIV outpatient/ambulatory care visit with this provider. When responding to this ID, keep these points in mind: • The visit must meet the RWHAP definition of an outpatient/ambulatory medical care visit. • You are not expected to resort to unreasonable measures to locate this information in your files. If you are unable to identify the first date of service, please report the earliest date available in your records. • This visit may have occurred before the start of the reporting period. • This visit may or may not be a RWHAP-funded visit. • The date of first HIV outpatient/ambulatory medical care visit does not change in subsequent reports.	
Dates of the client's outpatient ambulatory care visits	**XML Variable Name:** ClientReportAmbulatoryID
Description: Report all dates (MM/DD/YYYY) of the client's outpatient/ambulatory care visits in this provider's HIV care setting with a clinical care provider during the reporting period, regardless of the payer. A clinical care provider is a physician, physician assistant, clinical nurse specialist, nurse practitioner, or other health care professional who is certified in his or her jurisdiction to prescribe antiretroviral (ARV) therapy. The number of outpatient ambulatory care visit dates reported for this ID should be equal to or greater than the number of visits reported in ID 16.	
Client's CD4 Test	**XML Variable Name:** ClientReportCd4TestID • Count

	• Service Date
Description: Report the value and test date for all CD4 count tests administered to the client during the reporting period. The CD4 cell count measures the number of T-helper lymphocytes per cubic millimeter of blood. It is a good predictor of immunity. As CD4 cell count declines, the risk of developing opportunistic infections increases. The test date is the date the client's blood sample is taken, not the date the results are reported by the lab.	
Client's Viral Load Test	**XML Variable Name:** ClientReportViralLoadTestID • Count • Service Date
Description: Report the value and test date for all viral load tests administered to the client during the reporting period. Viral load is the quantity of HIV RNA in the blood and is a predictor of disease progression. Test results are expressed as the number of copies per milliliter of blood plasma. The test date is the date the client's blood sample is taken, not the date the results are reported by the lab. If a viral load count is undetectable, you should report the lower bound of the test limit. If the lower bound is not available, report 0.	
Client prescribed PCP prophylaxis	**XML Variable Name:** Prescribed**PCP**ProphylaxisID
Description: PCP prophylaxis is drug treatment to prevent *Pneumocystis jiroveci* pneumonia. It is a major cause of mortality among people with HIV infection, yet it is almost entirely preventable and treatable. People with CD4 T-cell counts under 200 cells/mm3 are at greatest risk of developing PCP. Indicate if clients were prescribed a PCP prophylaxis at any time during the reporting period. **NOTE:** Select "yes" if the client began or was continuing a prophylactic regimen during the reporting period. • Yes • No • Not medically indicated • No, client refused	
Client prescribed ART	**XML Variable Name:** PrescribedArtID
Description: ART is antiretroviral therapy, an aggressive anti-HIV treatment including a combination of three or more drugs with activity against HIV whose purpose is to reduce viral load to undetectable levels. **NOTE:** Report "yes" if the client began or was continuing on ART during the reporting period. • Yes. This includes clients who were not adherent to the prescribed therapy. • No, not ready (as determined by clinician) • No, client refused • No, intolerance, side effect, toxicity • No, ART payment assistance unavailable • No, other reason	
Client has been screened for TB since HIV diagnosis	**XML Variable Name:** ScreenedTBSinceHivDiagnosisID
Description: Indicate if the client has been screened for TB since his or her HIV diagnosis. • No • Yes • Not medically indicated • Unknown	

Client was screened for syphilis during this reporting period	**XML Variable Name:** ScreenedSyphilisID
Description: Syphilis is a sexually transmitted disease (STD) that can be diagnosed by examining material from a chancre (infectious sore) using a dark-field microscope or with a blood test. This element is not required for clients ages 17 or younger who are not sexually active. Has the client been screened for syphilis during this reporting period? • Yes • No • Not medically indicated	
Client was screened for hepatitis B since HIV diagnosis	**XML Variable Name:** ScreenedHepatitisBSinceHivDiagnosisID
Description: Indicate if the client has been screened for hepatitis B since his or her HIV diagnosis. • No • Yes • Not medically indicated • Unknown	
Client has completed the vaccine series for hepatitis B	**XML Variable Name:** VaccinatedHepatitisBID
Description: The hepatitis B vaccine series is a sequence of shots that stimulate a person's natural immune system to protect against HBV. Has the client completed the vaccine series for hepatitis B? •Yes •Not medically indicated •No **Please refer to the RSR Manual under OAHS for further instructions regarding:** if the person's hepatitis B vaccination is in progress or the client has a hepatitis B surface antibody test that is positive/reactive and hepatitis B antigen that is negative/non-reactive.	
Client screened for hepatitis C since HIV diagnosis	**XML Variable Name:** ScreenedHepatitisCSinceHivDiagnosisID
Description: Indicate if the client has been screened for hepatitis C since his or her HIV diagnosis. •No •Yes •Not medically indicated •Unknown	
Client was screened for substance use	**XML Variable Name:** ScreenedSubstanceAbuseID
Description: Substance use screening is a quick, simple way to identify clients who may need further assessment or treatment for substance use disorders. Screening may include biomarkers (e.g., positive drug screen or liver disease) and client reports of consumption patterns. Substance use screening may be administered by a substance abuse treatment professional or by a trained health care professional in another medical/clinical discipline. Was the client screened for substance use (alcohol and drugs) during the reporting period? • No • Yes • Not medically indicated	
Client received mental health screening	**XML Variable Name:** ScreenedMentalHealthID
Description: Mental health screenings include the use of brief structured instruments or commonly used questions to assess potential mental health problems. Screenings are designed to determine whether the client	

presents signs or symptoms of a mental health problem and if the client should be referred to a mental health professional. Screens are not diagnostic tools and, although typically administered by a mental health professional, may be administered by trained health care professionals in other medical/clinical disciplines. Was a mental health screening conducted for the client during this reporting period? • No • Yes • Not medically indicated	
Client received a Pap Smear	**XML Variable Name:** Received CervicalPapSmearID
Description: Reported for HIV-positive women only, only report a value for a cervical smear. Do not report a value for an anal test for male or female clients. A Pap smear or screening is a way to examine cells taken from a woman's cervix. It can detect cell changes that may be pre-cancerous as well as hidden, small tumors that may lead to cervical cancer. Did the client receive a Pap smear during this reporting period? • No • Yes • Not medically indicated • Not applicable	
Client was pregnant	**XML Variable Name:** PregnantID
Description: Reported for HIV-positive women only, do not report a value for male clients, unless the client is transgendered. Was the client pregnant during the reporting period? • No • Yes • Not applicable	
Positive HIV Test Date	**XML Variable Name:** HIVPosTestDateID
Description: Date of the client's first documented positive HIV test during the reporting period. It can be a positive HIV test from another site, as long as it is documented and not a client self-report. May be the client's HIV confirmatory test date. **Positive HIV Test Date:** • mm/dd/yyyy (Must be within the reporting period year.)	
OAMC Link Date	**XML Variable Name:** OAMCLinkDateID
Description: Date of client's first OAMC medical care visit after positive HIV test. The OAMC visit date must be a visit with a prescribing provider and cannot be a date before that reported in ID 73. **HIV OAMC linkage date:** • mm/dd/yyyy (Must be within the reporting period and on the same day or later than positive HIV test date.)	