STANDARDS OF CARE

Los Angeles County Commission on HIV

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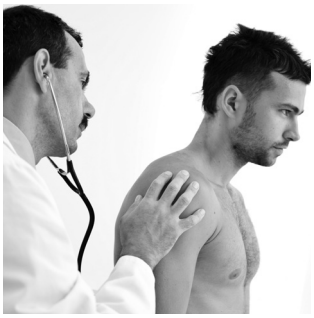


STANDARDS OF CARE

Los Angeles County Commission on HIV

MEDICAL OUTPATIENT SERVICES

EXECUTIVE SUMMARY

SERVICE INTRODUCTION

HIV/AIDS medical outpatient (MO) services are up-to-date educational, preventive, diagnostic and therapeutic medical services provided by licensed health care professionals with requisite training in HIV/AIDS. Such services will include care for people living with HIV throughout the entire continuum of the disease.

Ambulatory/outpatient medical services include:

- Medical evaluation and clinical care including sexual history taking
- Medical specialty services
- Medical care coordination
- Adherence counseling
- Laboratory testing (including drug resistance and other specialized tests)
- Nutrition therapy
- HIV prevention in ambulatory/outpatient settings
- Sexually transmitted infection (STI) prevention and testing

The goals of MO services include:

- Interrupting or delaying the progression of HIV disease and STIs
- Preventing and treating opportunistic infections
- Promoting optimal health
- Interrupting further HIV and STI transmission by providing the background for appropriate behavioral change

SERVICE/ORGANIZATIONAL LICENSURE CATEGORY

At minimum, all MO services staff will be able to provide linguistically and culturally 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 and STI 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.

SERVICE CONSIDERATIONS

General Considerations: MO services will be patient-centered, respecting the inherent dignity of the patient. Programs must ensure that patients are given the opportunity to ask questions and receive accurate answers regarding services provided by MO practitioners

and other professionals to whom they are referred. Such patient-practitioner discussions are relationship-building and serve to develop trust and confidence. Patients must be seen as active partners in decisions about their personal health care regimen. Practitioners are directed to patient-oriented HIV/AIDS care and prevention websites such as Project Inform (www.projectinform.org) and The Body (www.thebody.com) for more information about discussing HIV/AIDS from a patient-centered approach.

Medical Evaluation and Clinical Care: MO programs must confirm the presence of HIV infection and provide tests to diagnose the extent of immunologic deficiency in the immune system. Additionally, programs must provide diagnostic and therapeutic measures for preventing and treating the deterioration of the immune system and related conditions that conform to the most recent clinical protocols. At minimum, these services include regular medical evaluations; appropriate treatment of HIV infection; and prophylactic and treatment interventions for complications of HIV infection, including opportunistic infections, opportunistic malignancies, other AIDS-defining conditions and other STIs.

Medication Adherence Counseling: All HIV treatment adherence counseling will be provided in accordance with the Commission on HIV guidelines and procedures, and local laws and regulations. Treatment adherence counseling should be provided in the context of a medical or medical care coordination visit by either a medical provider. Adherence assessments will be performed on a regular basis and reported as medical progress notes. Referrals to the Medical Care Coordination (MCC) team for more thorough adherence counseling will be made by the provider when appropriate.

Services promote optimal health.

Medical Specialty Services: MO programs must make referrals to medical specialty providers who meet two requirements:

1. Are licensed as a physician (Medical Doctor (MD) or Doctor of Osteopathy (DO)) by the Medical Board of California or by the California Board of Osteopathic Examiners; and

2. Have completed the training and examination process required for certification by the respective national medical specialty professional board, or meets requirements for board-eligibility.

Nutrition Screening and Referral: All nutrition counseling services will be provided in accordance with published standards of care, Commission on HIV guidelines and procedures, and in accordance with California Business and Professions Code section 2585-2586.8, as well as local laws and regulations.

Medical Care Coordination Services: All MO programs must partner with medical care coordination services, either directly or through cooperative agreements. Medical care coordination services are supervised and overseen by a team consisting of a registered nurse and a master's level patient care manager.

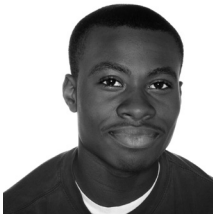
HIV Prevention in Ambulatory/Outpatient Settings: HIV prevention is a critical component to ongoing care for people living with HIV. Prevention services provided in MO clinics include HIV counseling, testing and referral; STI counseling, testing and referral; partner counseling; prevention and medical care; and referral for intensive services.

Common Service Components: Common service components include:

- Patient intake
- Referral
- Patient education
- Patient records
- Patient retention
- Case closure







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MEDICAL OUTPATIENT SERVICES

SERVICE INTRODUCTION

HIV/AIDS medical outpatient (MO) services are up-to-date educational, preventive, diagnostic and therapeutic medical services provided by licensed health care professionals with requisite training in HIV/AIDS. Such services will include care for people living with HIV throughout the entire continuum of the disease.

Ambulatory/outpatient medical services include:

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- Medical specialty services
- Medical care coordination
- Adherence counseling
- Laboratory testing (including drug resistance and other specialized tests)
- Nutrition screening and referral
- HIV prevention in ambulatory/outpatient settings
- Sexually transmitted infection (STI) prevention and testing

All programs will use available standards of care to inform their services and will provide services in accordance with legal and ethical standards. Maintaining confidentiality is critical and its importance and cannot be overstated. All programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards for information disclosure.

The goals of MO services include:

- Interrupting or delaying the progression of HIV disease and STIs
- Preventing and treating opportunistic infections
- Promoting optimal health
- Interrupting further HIV and STI transmission by providing the background for appropriate behavioral change

The Los Angeles County Commission on HIV and Division of HIV and STD Programs (DHSP—formerly referred to as the Office of AIDS Programs and Policy (OAPP)—have developed this standard of care to set minimum quality expectations for service provision and to guarantee patients consistent care, regardless of where they receive services in the County.

Services provide the background for behavior change.

Recurring themes in this standard include:

- MO services will be patient-centered. Patients will be fully educated, informed and part of the decision-making process.
- MO service providers must strive to help integrate the complex network of services for their patients.
- HIV risk prevention education and adherence counseling must be part of every patient encounter.

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

- *Ambulatory/Outpatient Medical Care Services Service Description*, Department of Public Health, Office of AIDS Programs and Policy, 2004
- *Ambulatory/Outpatient Medical Care Contract Exhibit*, Office of AIDS Programs and Policy
- *Medical Specialty Standard of Care*, Office of AIDS Programs and Policy
- *Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents*, Department of Health and Human Services, 2015
- *HIV/AIDS Treatment Advocacy/Education Standard of Care,* Los Angeles County Commission on Health Services, 2002
- *Medical Nutrition Therapy Across the Continuum of Care*, 2nd Edition, The American Dietetic Association, 1998
- *Medical Nutrition Therapy Standard of Care*, Los Angeles County Commission on HIV, 2006
- *Medical Specialty Standard of Care*, Office of AIDS Programs and Policy, 2006
- *Nutrition Guidelines for Agencies Proving Food to People Living with HIV Disease*, 2nd Edition, Association of Nutrition Services Agencies, 2002
- *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, 2004
- *Primary Care Approach to the HIV-Infected*, New York State AIDS Institute, 2004
- *Medical Care Coordination Standard of Care*, Los Angeles County Commission on HIV, 2008
- *Treatment Adherence Services Contract Exhibit*, Office of AIDS Programs and Policy
- *Treatment Education Standard of Care*, Los Angeles County Commission on HIV, 2008
- *Counseling, Testing, Immune Assessment and Referral Services Contract Exhibit*, Office of AIDS Programs and Policy.
- *Case Management, Medical Special Rate Study, Department of Public Health*, Office of AIDS Programs and Policy, 2004
- *Drug Resistance Testing Service Description, Department of Public Health*, Office of AIDS Programs and Policy, 2004
- *AIDS Drug Assistance Program Service Description, Department of Public Health*, Office of AIDS Programs and Policy
- *Referral to Medical Specialty Services Service Description*, Department of Public Health, Office of AIDS Programs and Policy, 2004
- Standards of Care developed by several other Ryan White Title 1 Planning Councils. Most valuable in the drafting of this standard were Baltimore, 2003; Orlando, 2005; Boston, 2005; and Las Vegas
- Centers for Disease Control and Prevention (CDC) Sexually Transmitted Diseases Guidelines, 2015 (www.cdc.gov/std)

MEDICAL OUTPATIENT SERVICES

All MO services will be provided in accordance with published standards of care, Commission on HIV guidelines and procedures, and in accordance with California Business and Professions Code, as well as local laws and regulations.

Services will be provided by health care professionals with requisite training in HIV/AIDS, including physicians, physician assistants (PAs) and/or nurse practitioners (NPs). Such practitioners will be licensed to practice by the state of California.

Facilities providing MO services must be:

- Licensed as a medical clinic facility, approved through the Los Angeles County Department of Public Health, Health Division for Licensing and Certification, in cooperation with the California Department of Health Services (CDHS)
- Approved as an enrollment site by the CDHS and by the Los Angeles County Department of Public Health, DHSP
- Compliant with the Health Insurance Portability and Accountability Act, 1996 (HIPAA) and with the requirements of Title 17 and Title 22 of the California Code of Regulations
- Licensed and Medi-Cal certified by the Los Angeles County Department of Public Health, Health Division for Licensing and Certification in cooperation with CDHS and must comply with current federal and State standards for such programs (in order to be funded by DHSP)

Many of the MO care facilities funded by DHSP are also accredited by the Joint Committee on Accreditation of Healthcare Organizations (JCAHO) and/or are designated as federally qualified health care (FQHC) facilities by the federal Department of Health and Human Services (DHH). While JCAHO accreditation and FQHC status are not required, HIV/AIDS MO care programs are developed, implemented, and monitored with similar administrative and clinical capacities and competencies characteristic of clinics that are JCAHO accredited and/or FQHCs (or FQHC Look-a-Likes). (See the California Primary Care Association www.cpca.org and National Association of Community Health Centers, Inc. www.nachc.com).

MEDICAL SPECIALTY SERVICES

MO programs must make referrals to medical specialty providers who meet two requirements:

1. Licensed as a physician (Medical Doctor (MD) or Doctor of Osteopathy (DO)) by the Medical Board of California or by the California Board of Osteopathic Examiners

2. Completed the training and examination process required for certification by the respective national medical specialty professional board, or meets requirements for board-eligibility.

ADHERENCE COUNSELING

Medication adherence counseling will be provided in accordance with the Commission on HIV guidelines and procedures, and local laws and regulations. Medication adherence counseling should be provided in the context of a medical or medical care coordination

(MCC) visit by either a medical provider or a trained MCC team member. Adherence assessments should be performed on a regular basis and documented in medical progress notes and MCC documents.

NUTRITION SCREENING AND REFERRAL

All nutrition counseling services will be provided in accordance with published standards of care, Commission on HIV guidelines and procedures, and in accordance with California Business and Professions Code section 2585-2586.8, as well as local laws and regulations. Either MO or MCC providers are responsible for screening patients' nutritional needs, noting positive screens in the medical chart, and referring patients to medical nutrition therapy programs as needed.

Either the provider's own medical nutrition therapy program or a program to which they refer will operate under the direct supervision of a registered dietitian or nutritionist consistent with California Business and Professions Code section 2585-2586.8. Registered dietitians providing medical nutrition therapy services will have advanced knowledge of nutrition issues for people living with HIV, maintain membership in the HIV/AIDS Dietetic Practice Group, and maintain professional education (CPE) units/hours, primarily in HIV nutrition and other related medical topics as administered by the Commission on Dietetic Registration.

DEFINITIONS AND DESCRIPTIONS

Clinical trials are research studies focus on HIV pathology, treatment and management of complications and co-infections.

Counseling is a discussion with a patient/patient and/or family member about diagnostic results and impressions; prognosis; risks and benefits of treatment; instructions for treatment management and follow-up; treatment adherence; risk factor reduction and general education.

Dietitians must be registered dietitians and are experts in food and nutrition, promoting good health through proper eating. They supervise the preparation and service of food, develop modified diets and educate individuals and groups on good nutrition habits and self-management skills.

Drug resistance testing measures the pattern of resistance of HIV to antiretroviral medications. Genotypic testing looks for viral mutations and phenotypic testing measures the amount of drug needed to suppress replication of HIV.

HIV counseling and testing services provide testing for the presence of antibodies to HIV, counseling before and after taking the test, referrals to other services as needed by the patient and the provision of appropriate interventions based on the HIV/AIDS risks assessed.

Immune deficiency caused by HIV is a spectrum of disease ranging from asymptomatic HIV disease to AIDS as defined by the Federal Centers for Disease Control and Prevention (CDC).

Licensed, primary health care professional is defined as a physician, physician assistant and/or nurse practitioner providing primary HIV medical care. Such person will be licensed to practice by the state of California.

Linked referrals assist patients in accessing services including making an appointment for the indicated service.

Medical care coordination integrates the efforts of medical and social service providers by developing and implementing a therapeutic plan.

Medical nutrition therapy is provision of specific nutrition counseling and interventions to help treat HIV disease, including screening, referral, assessment, intervention and communication. Medical nutrition therapy involves both assessment and appropriate treatments to maintain and optimize nutrition status.

Medical specialty services provide consultation, diagnosis and therapeutic services for medical complications beyond the scope of practice of primary medical and nursing care for people living with HIV.

Medication adherence counseling is one-on-one counseling to maintain or improve the patient's adherence to the HIV prescribed regimen and case plan, and can be provided by professional medical staff or medical care coordination team member.

MO services are up-to-date educational, preventive, diagnostic and therapeutic medical services provided by licensed health care professionals with requisite training in HIV/AIDS.

MO visits are defined as face-to-face encounters between licensed primary health care professionals (physician, registered nurse (RN), nurse practitioner (NP), or (PA)) and patients involving evaluation, diagnosis and treatment. Procedures (e.g., drawing blood, collecting specimens, performing laboratory tests, taking X-rays, filling or dispensing prescriptions) without a face-to-face patient/practitioner encounter do not constitute a separate MO visit.

New patient is defined as an individual who is receiving MO services for the first time through a specific program or facility. A patient is only considered new once in any facility.

Nutrition screening and referral is a medical provider's initial assessment of a patient's nutritional needs, and subsequent action (referral for medical nutrition therapy) as needed.

Patient education contact is defined as a one-on-one encounter between the patient and treatment advocate involving educational activities that are consistent with the patient's individual service plan (ISP).

Patient support encounter involves activities consistent with the ISP, but which are supportive, not primarily educational, in nature.

Sexually active at increased risk individuals have been engaged in sexual activity without protection within the last 12 months; are sexually active with multiple sexual partners; are using drugs (particularly IDU/meth), and/or have had STDs within the last 12 months (*Centers for Disease Control and Prevention definition*).

Treatment adherence is defined as a patient's ability and level of success in following an HIV prescribed regimen.

Treatment education is the service designed to address patients' adherence to their treatment regimen and to educate them about their medications and treatment plan. Treatment education should be provided as part of the MO visit, and can be provided as a

separate, supplementary service (see *Treatment Education Standard of Care, Los Angeles County Commission on HIV, 2008*).

HOW SERVICE RELATES TO HIV

At the end of 2013, approxiately 60,050 people were estimated to be living with HIV infection in Los Angeles County. Los Angeles County comprises 40% of the total AIDS cases in the State of California (*Epidemiologic Profile of HIV in Los Angeles County*, 2013).

The treatment of HIV, now considered a chronic disease, is costly and time-consuming in its complexity and requires expertise and significant time for comprehensive assessment (Metsch, et al., 2004). Special attention must be given to the treatment of ethnic minorities, women and the poor. The HCSUS study found inferior patterns of care in blacks and Latinos compared with whites, the uninsured and Medicaid-insured compared with the privately insured, women compared with men, and other exposure groups compared with men who had sex with men (Shapiro, et al., 1999). A San Francisco study found that only about 30% of its HIV-infected urban poor took combination highly active antiretroviral medications compared with 88% of HIV-infected gay men (Bamberger, et al., 2000).

The management of HIV has become sufficiently complex that generalist primary care physicians cannot be expected to have specialized knowledge in this area, requiring multidisciplinary approaches for HIV care (Hecht et al., 1999). Non-expert generalists have been shown to deliver lower quality care than HIV-experienced physicians (Landon, et al., 2005). A retrospective cohort study done in a large HMO found that HIV care delivered by physicians with greater AIDS experience was associated with improved survival (Kitahata et al., 2003). In the same study, patients receiving infrequent primary care visits by the least experienced physicians were 15.3 times more likely to die than patients of the most experienced physicians (Kitahata et al., 2003). Optimal care for HIV, therefore, is a combination of experienced, knowledgeable HIV primary care, and specialty and subspecialty care (Hecht et al., 1999).

Adherence to medication is crucial to successful HIV treatment (Friedland & Williams, 1999). Inconsistent adherence can cause resistance to prescribed medications as well as to other medications in the same classes as those in a patient's regimen (Bamberger, et al., 2000). The initial antiretroviral regimen offers the optimum opportunity to control HIV replication. The first choice of therapy should be selected with future options in mind (Kuritzkes, 2004). If, however, resistance to antiretrovirals develops, resistance testing can help guide the clinician in the choice of future therapies (Gallant, 2000).

Medication adherence counseling services are intended to educate and empower patients to maximize participation in their own care and have been shown to be effective in helping stabilize or reduce viral loads and increase CD4 counts (Pennsylvania Department of Health, 2005; DeFino, Clark , Mogyoros, & Shuter, 2004). Other studies have demonstrated that adherence education produces similar results (Molassiotis, Lopez-Nahas, Chung, & Lam, 2003; Pradier, 2003). A study that compared an "adherence clinic" focusing on medication adherence with standard of care demonstrated significant improvement, with 69% of patients in the clinic group achieving medication adherence compared to 42% in the standard care group. In the same study, the mean decline in adherence from weeks 4 to 28 was also significant at 12% in the adherence clinic group and versus 22% in the standard of care group (Rathbun, et al., 2005). Other adherence interventions have demonstrated significant increases in medication refills and clinic appointments, increased drop-in visits

and fewer hospitalizations. Intervention participants also suffered significantly fewer opportunistic infections (McPherson-Baker, et al., 2002).

Nutrition also plays an important role in supporting the health and quality of life of people living with HIV (Fields-Gardner, et al., 2004), and nutritional counseling has been shown to be an effective tool in their care (Nerad, et al., 2003). Individualized nutrition care plans can be essential in the medical management of people living with HIV (Fields-Gardner, et al., 2004).

Early identification of nutrition problems is critical to successful prevention and/or treatment. A thorough nutrition assessment is an important component of early intervention efforts to prevent the loss of body tissue (Fields-Gardner, 2004; Thomson & Rhodes, 1997). Such assessment is necessary to prioritize appropriate nutrition interventions and to develop a multidisciplinary nutrition plan (American Dietetic Association & Dietitians of Canada, 2004). Nutrition counseling and supplements have been shown to have a positive influence on health outcomes in people living with HIV (Nerad, et al., 2003; Rabeneck, et al., 1998; Berneis, et al., 2000).

Janssen and Valdiserri (2004) report CDC estimates of more than 15,000 HIV infections occurring in the United States annually from people who already know they are infected. While HIV-positive patients may be relatively well informed about HIV transmission and prevention, focus groups have reported having difficulty in using that information (Fischer, et al., 2004). In an analysis of behavioral surveillance data from HIV-positive MSMs interviewed in 12 states between 1995 and 2000, Denning and Campsmith (2005) found that one fifth of HIV-positive MSMs who had a single steady male partner with negative or unknown serostatus engaged in unprotected anal intercourse. Such data demonstrate that medical care providers must integrate prevention interventions into the routine care of their patients living with HIV (Janssen & Valdiserri, 2004; Fischer, et al., 2004). Such data demonstrate that medical care providers must integrate prevention interventions into the routine care of their patients living with HIV (Janssen & Valdiserri, 2004; Fischer, et al., 2004).

SERVICE COMPONENTS

HIV/AIDS MO services form the foundation for the Los Angeles County HIV/AIDS continuum of care (County of Los Angeles HIV/AIDS Comprehensive Care Plan, 2002). MO services are responsible for assuring that the full spectrum of primary care needs for patients are met either by the program directly or by referral to other health care agencies. Services will be provided to individuals living with HIV who are residents of Los Angeles County and meet Ryan White eligibility requirements.

MO services will be patient-centered, respecting the inherent dignity of the patient. Programs must ensure that patients are given the opportunity to ask questions and receive accurate answers regarding services provided by MO practitioners and other professionals to whom they are referred. Such patient-practitioner discussions are relationship building and serve to develop trust and confidence. Patients must be seen as active partners in decisions about their personal health care regimen. Practitioners are directed to patient-oriented HIV/AIDS care and prevention websites such as Project Inform (www.projectinform.org) and The Body (www.thebody.com) for more information about discussing HIV/AIDS from a patient-centered approach.

HIV MO services must be provided consistent with United States Public Health Service treatment guidelines (www.aidsinfo.nih.gov/).

Other established practice guidelines, standards and protocols, may be used to provide state-of-the-art prevention and care services for all patients, including the most recent versions of sources such as:

- Johns Hopkins AIDS Service (www.hopkins-aids.edu)
- New York Department of Health AIDS Institute (www.hivguidelines.org)
- HIV/AIDS Bureau (www.hab.hrsa.gov)
- Center for Disease Control Division of HIV Prevention – Treatment (www.cdc.gov)

The scope of this MO services standard is broad and varied, encompassing many distinct services and several separate contracts.

The core of the MO services standard is medical evaluation and clinical care that includes:

- Initial assessment and reassessment
- Follow-up treatment visits
- Additional assessments
- Laboratory assessment and diagnostic screening (including drug resistance testing)
- Medication service
- Antiretroviral (ARV) therapy
- Treatment adherence counseling
- Health maintenance
- Clinical trials
- Primary HIV nursing care
- Medical specialty services
- Nutrition screening and referral

In addition to this core service, the MO standard includes incorporation of the following services:

- Medical care coordination services
- HIV prevention in ambulatory/outpatient settings, including:
- HIV Counseling, Testing and Referral for Partners and Social Affiliates
- Partner Counseling and Referral Services (PCRS), postexposure prophylaxis (PEP), and preexposure prophylaxis (PrEP)
- Referral for Intensive Services

Finally, this standard addresses components common to all of the services previously discussed.

Common service components include:

- Patient intake
- Referral
- Patient education
- Patient records
- Patient retention
- Case closure

STANDARD	MEASURE
MO services will be patient-centered, respecting the dignity of the patient.	Supervision and program review to confirm.
MO services will be provided in accordance with PHS guidelines and other established standards and guidelines.	Program monitoring to confirm.

MEDICAL EVALUATION AND CLINICAL CARE

MO programs must confirm the presence of HIV infection and provide tests to diagnose the extent of immunologic deficiency in the immune system. Additionally, programs must provide diagnostic and therapeutic measures for preventing and treating the deterioration of the immune system and related conditions that conform to the most recent clinical protocols. At minimum, these services include regular medical evaluations; appropriate treatment of HIV infection; and prophylactic and treatment interventions for complications of HIV infection, including opportunistic infections, opportunistic malignancies and other AIDS defining conditions.

The following core services must be provided onsite or through referral to another facility offering the required service(s). Qualified health care professionals for these services include physicians, NPs and/or PAs except where indicated (see Staff Requirements and Qualifications for details about qualifications). RNs may provide primary HIV nursing care services and linkage to medical care coordination services.

HIV MO services must be provided consistent with United States Public Health Service treatment guidelines (www.aidsinfo.nih.gov/).

Other established practice guidelines, standards and protocols, may be used to provide state-of-the-art prevention and care services for all patients, including the most recent versions of sources such as:

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- New York Department of Health AIDS Institute (www.hivguidelines.org)
- HIV/AIDS Bureau (www.hab.hrsa.gov)
- Center for Disease Control Division of AIDS Prevention – Treatment (www.cdc.gov)
- John G. Bartlett, MD, *Abbreviated Guide to Medical Management of HIV Infection The Pocket Guide to Adult HIV/AIDS Treatment*
- Jean R. Anderson, MD (editor), *A Guide to the Clinical Care of Women with HIV*
- Guidelines for preventing opportunistic infections among HIV-infected persons (*Morbidity and Mortality Weekly Report*)
- CDC Sexually Transmitted Disease Treatment Guidelines (*Morbidity and Mortality Weekly Report*)- (www.cdc.gov/std)

STANDARD	MEASURE
MO evaluation and treatment scheduled for a minimum of every four months a minimum of every six months, If long-term stability and adherence are demonstrated.	Medical chart review to confirm.
MO core services will be provided by physicians, NPs and/or PAs. RNs will provide primary HIV nursing care services and linkage to medical care coordination.	Policies and procedures manual and medical chart review to confirm.

INITIAL ASSESSMENT AND REASSESSMENT

Every effort should be made to accommodate timely medical appointments for patients newly diagnosed with HIV or newly re-engaging in HIV medical care. Clinics may receive requests for appointments from patients directly, from HIV test counselors, or from "linkage" staff such as patient navigators, whose role is to refer and actively engage patients back in medical care. If possible, patients should see their medical provider (or the MCC team) on their first visit to the clinic to help improve their success in truly engaging in their medical care.

The initial assessment of HIV-infected individuals must be comprehensive in its scope, including physical, sociocultural and emotional assessments and may require two to three outpatient visits to complete. Unless indicated more frequently by a patient's changing health condition, a comprehensive reassessment should be completed on an annual basis. The MO practitioners (physician, NP, PA or RN) responsible for completing the initial assessment and reassessments will use assessment tools based on established HIV practice guidelines. While taking steps to ensure a patient's confidentiality, the results of these assessments will be shared with medical care coordination staff to help identify and intervene on patient needs.

An initial assessment and annual reassessment for HIV-infected patient should include a general medical history; a comprehensive HIV-related history, including a psychosocial history; sexual and substance abuse histories; and a comprehensive physical examination. When obtaining the patient's history, the practitioner should use vocabulary that the patient can understand, regardless of education level.

General medical histories should include (at minimum):

- History of present illness
- Past hospitalizations, past and current illnesses
- Past immunizations
- Travel history and place of birth
- Sexual history
- Occupational history and hobbies
- Pets/animal exposures
- Current treatment, prescription and non-prescription medicines (including complementary and alternative therapies, illicit substances and hormones)
- Allergies
- Full review of systems
- Mental health

Comprehensive HIV-related histories should include (at minimum):

- HIV treatment history and staging
  - Most recent viral load and CD4 count
  - Nadir CD4 and peak viral load
  - Current and previous ARV regimens
  - Previous adverse ARV drug reactions
  - Previous adverse reactions to drugs used for opportunistic infection prophylaxis
- History of HIV-related illness and opportunistic infections
- History of sexually transmitted diseases (STDs)
- History of tuberculosis (TB)
- History of hepatitis and hepatitis vaccines
- Psychiatric history
  - Diagnosed psychiatric diseases
  - Previous/current treatment for psychiatric diseases
  - Disability related to psychiatric disease
  - Homicidality and suicidality
- Sociocultural assessment
- Transfusion or blood product history, especially before 1985
- Review of sources of past medical care (obtaining past medical records whenever possible)
- HIV-specific review of systems
  - Skin
  - Eyes

  - Ear, nose and throat
  - Stomatognathic
  - Pulmonary
  - Cardiovascular
  - Gastrointestinal/hepatic
  - Endocrine
  - Genitourinary
  - OB/GYN
  - Dermatologic
  - Musculoskeletal
  - Neurologic
  - Hematopoietic
  - Metabolic
- Sexual history
  - Sexual activity
  - Sexual practices
  - Gender identity
  - Past and current partners
  - Risk behavior assessment
- Substance use history
  - Past and current use and types of drugs, including alcohol
  - Frequency of use and usual route of administration
  - Risk behavior assessment
  - History of treatment
- Tobacco use history

Comprehensive physical exams should include (at minimum):

- Temperature, vital signs, height and weight
- Pain assessment
- Ophthalmologic examination
- Ears, nose, and throat examination
- Dermatological examination
- Lymph node examination
- Oral examination
- Pulmonary examination
- Cardiac examination
- Abdominal examination
- Genital examination
- Rectal examination
- Neurological examination

STANDARD	MEASURE

Comprehensive baseline assessment will be completed by physician, NP, PA or RN and updated, as necessary.	Comprehensive baseline assessment and updates/ follow-up treatment (as necessary) in patient medical chart to include:
	• General medical histories (at minimum):
	  • History of present illness
	  • Past hospitalizations, illnesses
	  • Past immunizations
	  • Travel history, place of birth
	  • Sexual history
	  • Occupational history
	  • Pets/animal exposures
	  • Current treatment, medicines
	  • Allergies
	  • Full review of systems
	  • Mental health
	• Comprehensive HIV-related histories (at minimum):
	  • HIV treatment history and staging
	  • History of HIV-related illness and infections
	  • History of sexually transmitted diseases
	  • History of TB
	  • History of hepatitis and vaccines
	  • Psychiatric history
	  • Sociocultural assessment
	  • Transfusion/blood product history
	  • Past medical care review and obtaining medical records
	  • HIV-specific review of systems
	  • Sexual history
	  • Substance use history
	  • Tobacco use history
	• Comprehensive physical exams (at minimum):
	  • Temperature, vital signs, height and weight
	  • Pain assessment
	  • Ophthalmologic
	  • Ears, nose, and throat
	  • Dermatological
	  • Lymph node
	  • Oral
	  • Pulmonary
	  • Cardiac
	  • Abdominal
	  • Genital
	  • Rectal
	  • Neurological

FOLLOW-UP TREATMENT VISITS

Patients should have follow-up visits scheduled every three to four months, except at the practitioner's discretion when a patient has demonstrated long-term stability and adherence in his/her medical regime. The U.S. Public Health standard requires at least two visits a year. If the patient is clinically unstable or poorly adherent, monthly follow-up should be considered. Visits should be scheduled more frequently at entry to care, when starting or changing ARV regimens, or for management of acute problems. Due to the complex nature of HIV treatment, ongoing HIV MO visits must be flexible in duration and scope, requiring that programs develop practitioner clinic schedules allowing for this complexity.

At minimum, a medical visit for a returning patient will include a problem focused history, problem-focused examination and straightforward medical decision-making.

Follow-up visits should record and address:

- Temperature, vital signs, height and weight
- Problems list status and updates including sexual history
- Pain assessment
- Adherence with the treatment plan
- In addition to regularly scheduled viral load measurements (see Laboratory Assessment and Diagnostic Screening), viral load also should be measured according to prevailing medical standards and current guidelines.
- Resistance testing should be performed (if feasible) for patients when viral failure to ARV has been demonstrated and/or when suboptimal suppression of viral load occurs (see more detailed discussion in Drug Resistance Testing)
- Laboratory tests (as outlined in Laboratory Assessment and Diagnostic Screening)
- Prophylaxis for opportunistic infections offered to each patient as indicated by immune status. Refer to current guidelines and prevailing standards for prophylaxis of opportunistic infections from DHHS Guidelines for Opportunistic Infections (www.aidsinfo.nih.gov/). Documentation of current therapies should be maintained on all patients receiving prophylaxis.
- HIV-infected women should have a documented cervical Pap smear dated within the last year. Normal smears should be followed with a second smear in six months. If both results are negative, subsequent Pap smears should be performed annually. Smears showing severe inflammation or reactive changes should be reevaluated within three to six months.
- Diagnosis of SIL 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.
- Regular discussions of family planning and contraception should be conducted with female patients. For patients who are pregnant, the medical provider should discuss pregnancy and treatment options.
- Anal and rectal exams should be performed at least annually. 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. (As this is an area of emerging data, any newly adopted national guidelines are recommended if/when they are disseminated.)
- 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 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.
- Advance directives, durable powers of attorney, living wills and other planning documents, including POLST (physician's orders for life sustaining treatment) and DNR (do not resuscitate) status, should be addressed at the beginning of treatment and at any appropriate time in the course of the illness.
- Patients with CD4 counts below 50 should be referred for ophthalmic examination by a trained retinal specialist for screening or as recommended by that specialist, according to prevailing medical standards and current guidelines.
- Follow-up should be conducted as recommended by the specialist or clinical judgment.
- Documentation of discussions of safer sex practices for both men and women. Patients in sero-discordant relationships should be educated about options for HIV pre-exposure prophylaxis (PrEP) or post-exposure prophylaxis (PEP) for their partners. Referrals for

PrEP and PEP should be made for these partners.

Following standards of care for HIV prevention and treatment, MO practitioners must include the following in each patient encounter:

- Providing brief HIV and STI prevention messages (asking patients about risk behaviors, and positively reinforcing patient's report of risk reduction behavior)
- Asking patients about problems and concerns with medication adherence and making suggestions to support adherence (such as pill boxes, alarms)
- Screening patients' nutritional needs and referring them for medical nutrition therapy services when and as needed
- Asking patients about their social living conditions, ensuring that lack of housing, food or other social needs do not become a barrier to treatment adherence
- Providing patient education on HIV disease, symptoms, medications and treatment regimens to increase patient participation in treatment decision-making (see www.IHI.org for Institute for Healthcare Improvement guidelines on "Self Management"); patient education on medications will include instructions, risks and benefits, compliance, side effects and drug interaction
- Building and maintaining patient relationships, increasing the likelihood that patients may ask for needed emotional support, or talk with practitioners about substance abuse issues

STANDARD	MEASURE
Follow-up visits for patients receiving ARV therapy should be scheduled every three to four months, except at the practitioner's discretion when a patient has demonstrated long-term stability and adherence in his/her medical regime. Follow-up visits should be scheduled every three to six months for patients who are not receiving ARV therapy. U.S. Public Health Standards require at least two visits annually. Follow-up visits should be scheduled more frequently at entry to care, when starting or changing ARV regimens, or for management of acute problems.	Patient medical chart to confirm frequency.
Follow-up visits should include (at minimum): • Temperature, vital signs, height and weight • Problems list and updates including sexual history • Pain assessment • Treatment plan adherence • Viral load at regular intervals and prior to and after ARV treatment initiation • Resistance testing (if necessary) for ARV viral failure • Suboptimal viral load suppression • Laboratory tests • Opportunistic infection prophylaxis and documentation • 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 women) and safer sex discussions and documentation	Patient medical chart to confirm referrals and/or content of follow-up visits.

STANDARD	MEASURE
Each patient encounter 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	Progress notes in patient chart to confirm.

OTHER ASSESSMENTS

Specialized assessments leading to more specific services may be indicated for patients receiving MO services. MO programs must designate a member of the treatment team (physician, RN, NP or PA) to make these assessments in the clinic setting. The following specialized assessments must be made available as part of the MO services:

- An ARV readiness assessment at first diagnosis of HIV infection for all patients starting combination therapies (see: www.hivguidelines.org AIDS Institute Clinical Guidelines, Best Practices, *"Promoting Adherence to HIV Antiretroviral Therapies."*).

  The assessment should include:
  - A medication adherence assessment regularly as needed for those not fully adherent
  - Level of knowledge and understanding about the HIV disease process
  - Primary health care services and adherence to these services
  - Awareness of available treatment options, clinical trials and resources
  - Literacy
  - Current or future adherence barriers
  - Support system

  Patients with full adherence do not need adherence assessments every six months, but documentation in the medical chart should demonstrate continued adherence at least every six months.

  For patients enrolled in MCC services, the medical care coordination staff may do this assessment and deliver the adherence interventions. The MCC assessment, which is performed at least every six months, will document adherence for patients in MCC.
- An HIV and STI prevention and education assessment for patients and their partners who need focused attention and support to modify high risk behaviors (see tools and guides in *Morbidity and Mortality Weekly Report*, July 18, 2003/Vol.52/No.RR-12). The assessment should be performed at least every six months.
- A nutrition screening for patients needing education and support for maintaining good nutrition, food and water safety, and food and nutritional interactions with treatment regimens (see the Commission on HIV's *Nutrition Therapy Standard of Care*, 2005). An assessment should be performed as baseline, and follow-up screenings performed and documented in the medical charts at least annually.

STANDARD	MEASURE
Assessments will be performed as indicated, including: • ARV readiness assessment at first diagnoses of HIV infection • Treatment adherence assessment regularly as needed for those patients who are not fully adherent.MCC assessment performed at least every six months • HIV and STI prevention and education assessment performed every six months • Nutrition assessment performed at baseline and nutrition screenings updated at least every six months	Assessments and updates noted documented in patient's medical chart.

LABORATORY ASSESSMENT AND DIAGNOSTIC SCREENING (INCLUDING DRUG RESISTANCE SCREENING)

MO 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. Programs must assure timely, quality lab results, readily available for review in medical encounters.

Baseline lab tests (preferably at fasting) for all HIV-positive persons should include:

- Complete Blood Count (CBC)
- Liver function tests
- Blood Urea Nitrogen (BUN)
- Creatinine
- Protein
- Albumin
- Glucose
- Triglycerides
- Cholesterol
- Syphilis serology, urine, Gonorrhea Chlamydia(GC)/Chlamydia and rectal/oral swabs for GC/Chlamydia
- Toxoplasma gondii antibody screening
- Urinalysis
- CD4 count and HIV-RNA viral load
- Chest X-ray
- Purified Protein Derivative (PPD) or IGRA (Quantiferon)
- Cervical Pap smear (if not done in past year)
- 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.

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 Public Health Standard guidelines, follow-up and ongoing lab tests for patients on ARV 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.

DRUG RESISTANCE TESTING

When appropriate, MO 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*. Practitioners are directed to HIV Resistance Web at www.HIVRESITANCEWEB.com for *Ask the Experts*; and www.thebody.com for the Forum on Drug Resistance and Staying Undetectable for more information.

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.

STANDARD	MEASURE
Baseline lab tests should include: • CBC • Liver function tests • BUN • Creatinine • Protein • Albumin • Glucose • Triglycerides • Cholesterol • Syphilis serology ,urine GC/Chlamydia, rectal GC, oral GC/Chlamydia (based on risk) • Toxoplasma gondii antibody screening • Urinalysis • CD4 count and HIV-RNA viral load • Chest X-ray • PPD • Cervical Pap smear (if not done in past year) • Hepatitis A screening for those not previously vaccinated • Hepatitis B and C serology	Record of tests and results on file in patient medical chart.
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 and urine and rectal GC/Chlamydia and oral GC for sexually experienced patients at increased risk	Record of tests and results on file in patient medical chart.

STANDARD	MEASURE
Appropriate health care provider will provide drug resistance testing as indicated.	Record of drug resistance testing on file in patient medical chart.
Drug resistance testing providers must follow most recent, established resistance testing guidelines, including genotypic testing on all naïve patients.	Program review and monitoring to confirm.

MEDICATION SERVICES

Medications should be provided to interrupt or delay the progression of HIV-disease, prevent and treat opportunistic infections, and promote optimal health. Patients should be referred to an approved AIDS Drug Assistance Program (ADAP) enrollment and, as indicated, to medical care coordination programs for additional assistance with public benefit concerns. Patients eligible for ADAP will be referred to a participating pharmacy for prescriptions on the ADAP formulary. If the patient requires medications that are not listed on the ADAP formulary or that can be reimbursed through other local pharmacy assistance resources, the MO program is responsible for making every effort possible to link them to medications and exercise due diligence for that effort consistent with their ethical responsibilities. For a more detailed discussion of ADAP services, please see the *ADAP Enrollment Standard of Care*, Los Angeles County Commission on HIV, 2008. For more information about Medical Care Coordination services, please see the *Medical Care Coordination Standard of Care*, Los Angeles County Commission on HIV, 2008.

STANDARD	MEASURE
Patients requiring medications will be referred to ADAP enrollment site. As indicated, patients will also be referred to medical care coordination programs for public benefits concerns.	ADAP referral documented in patient medical chart.
MO programs must exercise every effort and due diligence consistent with their ethical responsibilities to ensure that patients can get necessary medications not on the ADAP and local formularies.	Documentation in patient's medical chart.

ANTIRETROVIRAL (ARV) THERAPY

Antiretroviral therapy will be prescribed in accordance with the established guidelines based upon the DHSS *Guidelines for the Use of Antiretroviral Agents in HIV-infected Adults and Adolescents* (www.aidsinfo.nih.gov/). Decisions to begin ARV treatment must be collaborative between patient and MO practitioner. All patients will be given a readiness assessment (e.g., http://www.hivguidelines.org/public_html/center/best-practices/treatment_adherence/pdf/treat_adherence_full.pdf, New York AIDS Institute Clinical Guidelines, Best Practices, *Promoting Adherence to HIV Antiretroviral Therapies*, pp. 9-10) prior to prescribing ARV. Patients should be informed about the changes in lifestyle, body image and side effects that may accompany ARV treatment. Patients will be given the time necessary to make an informed decision about initiating treatment. This collaborative decision-making process must be documented in the patient medical record.

Decisions to begin ARV therapy should be based on an assessment of three major factors:

- The patient's clinical and immunologic status
- The patient's willingness and ability to adhere to the therapy prescribed
- The risk of long-term toxicity

Consistent with U.S. Public Health Standard guidelines, ARV treatment is recommended for all HIV-infected patients who feel ready, willing and able to commit to therapy.

STANDARD	MEASURE
ARV therapy will be prescribed in accordance with DHHS Guidelines for the Use of Antiretroviral Agents in HIV-infected Adults and Adolescents.	Program monitoring to confirm.
Patients will be part of treatment decision-making process.	Documentation of communication in patient medical chart.

MEDICATION ADHERENCE ASSESSMENT

Medication adherence assessment should be performed for patients, if need is indicated. An individual service plan (ISP) for treatment adherence may be developed for patients challenged by maintaining treatment adherence.

ISPs are tailored to each patient's specific needs identified in the assessment, and will include (at minimum):

- Short- and long-term projected goals
- Suggested interventions
- Proposed timelines and outcomes
- Patient tasks
- Provider tasks

ISPs will be developed in collaboration with the patient and, when possible, the patient's primary medical provider to address identified needs. ISPs will be revised at a minimum of every six months.

STANDARD	MEASURE
Medical providers or treatment adherence counselors will provide direct treatment adherence counseling or refreshers to all patients.	Notes in medical file indicating that counseling was provided, by whom and relevant outcomes.
Medical providers or treatment adherence counselors will develop treatment adherence assessments of patients where need is indicated.	Assessment on file in patient chart signed and dated by medical staff or treatment adherence counselor responsible, indicating, at a minimum, any follow-up intended.
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 chart, as applicable.
Medical providers or treatment adherence counselors will develop ISPs in collaboration with their patients and medical providers (when possible), as needed, based on specific needs identified in the assessment.	ISP on file in patient chart signed and dated by medical staff or treatment adherence counselor responsible and patient to include (at minimum): • Projected goals • Suggested interventions • Proposed timelines/outcomes • Patient tasks • Provider tasks
ISPs will be revised on an ongoing basis, but no less than every six months.	Revised ISPs signed and dated by treatment adherence counselors and patient on file in patient chart.

ONE-ON-ONE PATIENT EDUCATION

Medical providers and MCC staff will provide one-on-one patient education to make information about HIV disease and its treatments available, as necessary.

STANDARD	MEASURE
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 issues • Providing emotional support	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, interventions and progress made toward goals in the individual service plan (as appropriate)

ONE-ON-ONE PATIENT SUPPORT

Accompanying patients to medical visits and clinical trials visits when appropriate to assure patients are receiving services:

- Helping patients understand HIV disease and treatment options
- Helping patients with adherence issues
- Providing emotional support

STANDARD	MEASURE
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 issues • Providing emotional support	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, interventions and progress made toward goals in the individual service plan (as appropriate)

STANDARD HEALTH MAINTENANCE

MO practitioners will discuss general preventive health care and health maintenance with all HIV-infected patients routinely, and at a minimum, annually. MO programs will strive to provide preventive health services consistent with the most current recommendations of the U.S. Preventive Health Services Task Force (see http://www.ahrq.gov/clinic/prevnew.htm for current guidelines). MO practitioners will work in conjunction with medical care coordination programs and medical nutrition therapy programs to ensure that a patient's standard health maintenance needs are being met.

Standard health maintenance should include the following services and discussions (at minimum):

- Cancer screening (cervical, breast, rectal — per American Cancer Society guidelines)
- Influenza vaccine
- Tetanus/diphtheria update
- Pneumovax
- Meningococcal vaccine for high-risk men who have sex with men (MSM) and those who request it
- Pap screening
- Hepatitis screening, vaccination
- TB screening
- Family planning

- Counseling on safer sex and STD screening
- Counseling on food and water safety
- Counseling on nutrition, exercise and diet
- Harm reduction for alcohol and drug use
- Smoking cessation

In addition, patients should be taught how to perform breast and testicular self-examinations.

STANDARD	MEASURE
Practitioners will discuss health maintenance with patients annually (at minimum), including: • Cancer screening (per American Cancer Society guidelines) • Influenza vaccine • Tetanus/diphtheria update • Pneumovax • Meningococcal vaccine for high-risk MSM and those who request it • Pap screening • Hepatitis screening, vaccination • TB screening • Family planning • Counseling on safer sex and STD screening • Counseling on food and water safety • Counseling on nutrition, Exercise and diet • Harm reduction for alcohol and drug use • Smoking cessation	Annual health maintenance discussions will be documented in patient medical chart.

COMPLEMENTARY, ALTERNATIVE AND EXPERIMENTAL THERAPIES

MO practitioners must be aware if their patients are accessing complementary, alternative and experimental therapies. Providers are encouraged to discuss at regular intervals complementary and alternative therapies with patients, discussing frankly and accurately both their potential benefits and potential harm. Practitioners may consult the NIH National Center for Complementary and Alternative Medicine (http://nccam.nih.gov) for more information. Patients can be referred to the New Mexico AIDS InfoNet (http://AIDSinfonet.org) for "patient-friendly" information on complementary and alternative therapies.

STANDARD	MEASURE
Practitioners must know if their patients are using complementary and alternative therapies and are encouraged to discuss these therapies with their patients regularly.	Record of therapy use and/or discussion on file in patient medical record.

CLINICAL TRIALS

MO programs should develop relationships with centers that provide AIDS clinical research. MO practitioners must also discuss patient participation in clinical trial research projects. Patients and practitioners are directed to the AIDS Clinical Trials Information Service which provides current information on federally and privately sponsored clinical trials (http://aidsinfo.nih.gov/clinical_trials/), as well as the AIDS Clinical Trials Group (www.actis.org), AIDS Clinical Trials Info Hotline (800-874-2572) and the HIV/AIDS Treatment Info Service (www.hivatis.org) for more information.

STANDARD	MEASURE
MO programs must develop relationships with centers that provide AIDS clinical research.	Documentation of linkages on file at provider agency.
MO practitioners must provide information about participation in clinical trials to patients.	Documentation of discussion on file in patient medical chart.

PRIMARY HIV NURSING CARE

MO programs will provide primary HIV nursing care performed by an RN and/or appropriate licensed health care provider. Services will be coordinated with medical care coordination programs to ensure the seamless, non-duplicative, and most appropriate delivery of service. Primary nursing services will include (but not be limited to):

- Nursing assessment, evaluation and follow-up
- Triage as appropriate
- Consultation and ongoing communication with primary practitioner
- Patient counseling
- Patient and family education
- Provision of any service which requires substantial specialized nursing skill
- Initiation of appropriate preventive nursing procedures
- Coordination of other services to assist in the medical management of patient in conjunction with medical care coordination

STANDARD	MEASURE
RNs and/or other appropriate licensed health care providers in MO programs will provide primary HIV nursing care to include (at minimum): • Nursing assessment, evaluation and follow-up • Triage • Consultation/communication with primary practitioner • Patient counseling • Patient/family education • Services requiring specialized nursing skill • Preventive nursing procedures • Service coordination in conjunction with medical care coordination	Documentation of primary HIV nursing care service provision on file in patient medical chart.

MEDICAL SPECIALTY SERVICES

HIV/AIDS MO service programs are required to provide access to specialty and subspecialty care to fully comply with the Public Health Service (PHS) Guidelines (www.aidsinfo.nih.gov/).

Such medical specialties for HIV-related specialty or subspecialty care include (but are not limited to):

- Cardiology
- Dermatology
- Ear, nose and throat (ENT) specialty
- Gastroenterology
- Gynecology
- Infusion therapy
- Neurology
- Ophthalmology
- Oncology
- Oral health

- Pulmonary medicine
- Podiatry
- Proctology
- General surgery
- Urology
- Nephrology
- Orthopedics
- Obstetrics

MEDICAL SPECIALTY REFERRAL

Referrals to medical specialists are made as complications occur that are beyond the scope of practice of primary HIV medical and nursing care. Such complications require referral to specialty and subspecialty physicians for consultation, diagnosis and therapeutic services. In some cases, the MO practitioner may need only to consult verbally with a medical specialist for clarification and confirmation on an approach to HIV clinical management. In other cases, the physician may need to refer a patient to a medical specialist for diagnostic and therapeutic services. Medical specialty services are considered consultative; patients will be referred back to the original MO clinic for ongoing primary HIV medical care.

MO programs must develop written policies and procedures that facilitate referral to medical specialists. All referrals must be tracked and monitored. The results of the referrals must be documented in the patient's medical record.

When referring to medical specialists, medical outpatient practitioners are responsible for:

- Assessing a patient's need for specialty care
- Providing pertinent background clinical information to medical specialist, including (but not limited to):
  - Copy of relevant primary care notes
  - Current medications
  - Copies of labs or imaging procedures
  - Copies of relevant previous consultation reports
- Making a referral appointment with the medical specialist
- Communicating all referral appointment information
- Tracking and monitoring referrals and results
- Assuring the patient returns to the MO program of origin for continued HIV/AIDS primary health care services

STANDARD	MEASURE
MO programs must develop policies and procedures for referral to all medical specialists.	Referral policies and procedures on file at provider agency.
All referrals will be tracked and monitored.	Record of linked referrals and results on file in patient medical record.
In referrals for medical specialists, medical outpatient-specialty practitioners are responsible for: • Assessing a patient's need for specialty care • Providing pertinent background clinical information to medical specialist • Making a referral appointment • Communicating all referral appointment information • Tracking and monitoring referrals and results • Assuring the patient returns to the MO program of origin	Record of referral activities on file in patient medical record.

COORDINATION OF SPECIALTY CARE

It is imperative that MO programs and medical specialists coordinate their care to ensure integration of specialty treatment with primary HIV medical care. As noted above, MO programs must provide pertinent background clinical information in their referrals to medical specialists. In turn, specialists within the County-contracted system must provide to MO programs a written report of their findings within two weeks of seeing a referred patient. Medical specialists within the County-contracted system must telephone MO programs within one business day in the event that urgent matters arise, to follow up on unusual findings or to plan a required hospitalization.

STANDARD	MEASURE
Specialists within the County-contracted system must provide written reports within two weeks of seeing a referred patient.	Specialty report on file at provider agency.
Specialists within the County-contracted system must telephone MO programs within one business day: • When urgent matters arise • To follow up on unusual findings • To plan required hospitalization	Documentation of communication in patient file at provider agency.

LETTERS OF AGREEMENT (LOAS)

To demonstrate collaboration and formal relationship with providers, programs must have written LOAs or contracts with all medical specialists used by MO practitioner for referral. The LOAs must describe the procedure for written and verbal communications between the referring MO practitioner and the consulting medical specialists. Follow-up between specialty providers and MO providers is of critical importance.

LOAs should outline (at minimum):

- Description of services provided by each party
- Fees, if any
- Restrictions on services
- Expectations and safeguards regarding client confidentiality
- Procedures related to sharing client information
- Timeframe for consult results, plan and/or follow-up
- Follow-up requirements
- Contact person for services issues and referral tracking
- Policies and procedures for tracking missed appointments
- Specific time frame for agreement
- Reporting requirements, documents and timeframes
- Participation in networks, case conferences or other meetings
- Participation in monitoring and quality management activities

STANDARD	MEASURE
MO programs will have written LOAs or contracts with all medical specialists utilized.	LOAs or contracts on file at provider agency that include (at minimum): • Description of services • Fees • Restrictions on services • Confidentiality expectations and safeguards • Procedures for sharing client information • Timeframes • Follow-up requirements • Contact person • Policies and procedures • Reporting requirements • Participation in networks, case conferences or other meetings • Quality management activities

NUTRITION SCREENING AND REFERRAL

Nutrition is a component of the Public Health Service standards of care in order to guard against malnutrition and wasting. The physician, NP, PA, RN or RD should screen all patients for nutrition concerns and provide a written prescription for all at-risk patients for medical nutrition therapy within six months of an individual becoming an active patient in the MO program.

In addition, patients should be referred to a registered dietitian for the following conditions:

- Physical changes and weight concerns
- Oral/Gastro-Intestinal (GI) symptoms
  - Metabolic complications and other medical conditions (diabetes, hyperlipidemia, hypertension, pregnancy, etc.)
  - Barriers to nutrition, including living environment and functional status
  - Behavioral concerns or unusual eating behaviors
  - Changes in diagnosis requiring nutrition intervention

A referral to medical nutrition therapy must include:

- A written order/referral with the diagnosis and desired nutrition outcome
- Signed copy of patient's consent to release medical information, if an external referral results from nutrition-related lab assessments

MO programs may provide medical nutrition therapy onsite, or may refer patients in need of these services to specialized providers offsite.

All programs providing nutrition therapy (including MO services sites) must adhere to the Commission on HIV's *Nutrition Therapy Standard of Care* (2005).

STANDARD	MEASURE
MO practitioners should screen all patients for nutrition-related concerns for all at-risk patients.	Record of screening for nutrition related problems noted in patient's medical chart.
MO practitioners will provide a written prescription for all at-risk patients for medical nutrition therapy within six months of an individual becoming an active patient.	Record of screening for nutrition related problems noted in patient's medical chart.

STANDARD	MEASURE
When indicated, patients will also be referred to nutrition therapy for: • Physical changes/weight concerns • Oral/GI symptoms • Metabolic complications and other medical conditions • Barriers to nutrition • Behavioral concerns or unusual eating behaviors • Changes in diagnosis	Record of linked referral on file in patient medical chart.
Referral to medical nutrition therapy must include: • Written prescription, diagnosis and desired nutrition outcome • Signed copy of patient's consent to release medical information • Results from nutrition-related lab assessments	Record of linked referral on file in patient medical chart.

MEDICAL CARE COORDINATION (MCC) SERVICES

In order to best address the complex needs of their patients, MO providers are expected to partner with medical care coordination teams located at their clinics. MCC services are supervised and overseen by a team consisting of a registered nurse and a master's level patient care manager.

MCC services shall 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
- HIV prevention, education and counseling
- Patient retention services

For additional details, please see the *Medical Care Coordination Standard of Care,* Los Angeles Commission on HIV, 2008.

STANDARD	MEASURE
MO 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 • HIV prevention, education and counseling • Patient retention services	Documentation of medical care coordination services and/or referral on file in patient medical chart.

HIV PREVENTION IN AMBULATORY/OUTPATIENT MEDICAL SETTINGS

HIV prevention is a critical component to ongoing care for people living with HIV. Prevention services provided in MO clinics include HIV counseling, testing and referral; partner counseling; prevention and medical care; and referral for intensive services.

PREVENTION AND MEDICAL CARE

Consistent with the CDC's and the local Prevention Planning Committee (PPC)'s prevention standards, health care practitioners providing MO services are required to incorporate HIV prevention into the routine medical care of all HIV-infected patients.

MO practitioners will:

- Screen patients for risk behaviors
- Communicate prevention messages to patients
- Discuss sexual practices and drug use with patients
- Positively reinforce changes to safer behavior
- Refer patients for substance abuse treatment
- Facilitate partner notification, counseling and testing; provide education and referrals for partners to PrEP and PEP
- Identify and treat other sexually transmitted diseases (see *"Incorporating HIV Prevention into the Medical Care of Persons Living with HIV,"* Morbidity and Mortality Weekly Report, July 18, 2003/Vol.52/No.RR-12)

HIV COUNSELING, TESTING AND REFERRAL FOR PARTNERS AND SOCIAL AFFILIATES

MO programs must offer HIV counseling, testing, referral and partner counseling to all patients, partners and social affiliates through linkages and referral to HIV/AIDS testing sites (see: http://www.lapublichealth.org/aids/hivtestsites/Sites0503.pdf). Programs providing MO services must accept referrals of HIV-positive individuals from HIV/AIDS testing sites for medical evaluation and clinical care. MO programs are required to use the HIV Information Resources System (HIRS) that integrates HIV testing and counseling with treatment services.

PARTNER COUNSELING AND REFERRAL SERVICES (PCRS)

MO programs must offer partner counseling and referral services (PCRS), including partner notification services. At the initial visit, MO practitioners should discuss whether a patient's sex and needle-sharing partners have been informed of their exposure to HIV. During each routine follow-up visit, patients should be asked if there are new sex and/or needle-sharing partners who have not been informed of their exposure to HIV. MO practitioners should develop competencies in helping patients notify their partners. State law allows medical providers to disclose potential HIV exposure to HIV-infected persons' partners (see California Health and Safety Code). In these circumstances, the medical provider should disclose the test result and information about HIV transmission with the patient first, attempt to obtain the patient's voluntary consent for notification of his or her contacts, and notify the patient of the his or her intent to notify the contacts. Patients who need more intensive risk reduction interventions with partners must be referred to Los Angeles County's Prevention Case Management Program.

REFERRAL FOR INTENSIVE SERVICES

In some cases, the MO practitioner will need to refer a patient to more intensive prevention support services in conjunction with the medical care coordination team. Programs must develop written referral policies, procedures, and protocols to guide the MO practitioner in making successful prevention referrals. This referral process must incorporate the considerations described in "Engaging the Patient in the Referral Process" and "Referral

Guides and Information" (pages 13-14), "Incorporating HIV Prevention into the Medical Care of Persons Living with HIV," *Morbidity and Mortality Weekly Report*, July 18, 2003/ Vol.52/No.RR-12).

STANDARD	MEASURE
MO specialty practitioners must: • Screen for risk behaviors • Communicate prevention messages • Discuss sexual practices and drug use • Reinforce safer behavior • Refer for substance abuse treatment • Facilitate partner notification, counseling and testing • Identify and treat sexually transmitted diseases	Record of screening for nutrition related problems noted in patient's medical chart.
MO programs must offer HIV counseling, testing, referral to all partners and social affiliates.	Record of services on file in patient medical record.
Programs will provide PCRS services to all partners.	Record of PCRS services on file in patient medical record.
As indicated, patients will be referred for intensive prevention services in conjunction with their medical care coordination program.	Record of linked referral on file in patient medical record.
Programs must accept referrals from testing sites for medical evaluation and clinical care and are required to utilize HIRS.	Program review and monitoring to confirm.
Programs must develop written prevention referral policies, procedures and protocols.	Prevention referral policies and procedures on file at provider agency.

COMMON SERVICE COMPONENTS

PATIENT INTAKE

Intake is required for all patients who request or are referred to HIV/AIDS MO services. The intake determines eligibility and includes demographic data, emergency contact information, next of kin and eligibility documentation. The intake process also acquaints the patient with the range of services offered and determines the patient's interest in such services. Patient intake will be completed in the first contact with the potential patient.

As part of the intake process, the client file will include the following information (at minimum):

- Written documentation of HIV status
- Proof of Los Angeles County residency
- Verification of financial eligibility for services
- Date of intake
- Client name, home address, mailing address and telephone number
- Emergency and/or next of kin contact name, home address and telephone number

Required Forms: Programs must develop the following forms in accordance with state and local guidelines.

Completed forms are required for each patient:

- Release of Information (must be updated annually). New forms must be added for those individuals not listed on the existing Release of Information (specification should be made about what type of information can be released).
- Limits of Confidentiality (Confidentiality Policy)

- Consent to Receive Services
- Patient Rights and Responsibilities
- Patient Grievance Procedures

STANDARD	MEASURE
Intake process is begun during first contact with patient.	Intake tool, completed and in client file, to include (at minimum): • Documentation of HIV status • Proof of LA County residency • Verification of financial eligibility • Date of intake • Client name, home address, mailing address and telephone number • Emergency and/or next of kin contract name, home address and telephone number
Confidentiality policy and Release of Information is discussed and completed.	Release of Information signed and dated by patient on file and updated annually.
Consent for Services completed.	Signed and dated Consent in patient file.
Patient is informed of Rights and Responsibility and Grievance Procedures.	Signed and dated forms in patient file.

REFERRAL

All patients in the clinic should be screened for their need for Medical Care Coordination (MCC) services at least twice a year. Referrals to other health care and social service professionals are made as the patient's health status indicates and/or when the needs of the patient cannot be met by the MO program's established range of services. Medical care coordination team members can assist with referrals for patients enrolled in MCC.

MO programs must develop written policies and procedures that facilitate referral to all health and social service providers in the HIV/AIDS continuum of care. All referrals must be tracked and monitored. The results of the referrals must be documented in the patient's medical record.

As indicated, patients will be referred to the following services (at minimum, based on need):

- ADAP
- Medical care coordination
- Medical specialties
- Psychiatric and mental health services
- STI testing and counseling
- Substance abuse services
- Partner counseling and referral
- Medical nutrition therapy
- Oral health assessment and screening

An annual referral to oral health care is required (see the Commission on *HIV's Oral Health Care Standard of Care*, 2005).

STANDARD	MEASURE
MO programs must develop policies and procedures for referral to all health and social service providers in the HIV/AIDS continuum of care.	Referral policies and procedures on file at provider agency.

STANDARD	MEASURE
All referrals will be tracked and monitored.	Record of linked referrals and results on file in patient medical record.
As indicated, patients will be referred to (at minimum): • ADAP • Medical care coordination • Medical specialties • Psychiatric/mental health services • Substance abuse services • Partner counseling and referral • Medical nutrition therapy • Oral health assessment and screening Annual referral to oral health care is required.	Record of linked referrals and results on file in patient medical record.

PATIENT EDUCATION

Patient education is the responsibility of all MO practitioners. Patient education is ongoing and time must be allowed for education during each patient visit. Patients should be fully educated about their medical needs and treatment options within the standards of medical care. MO practitioners will document the patient education encounter and content in the medical record.

Specifically, treatment adherence assessment should be provided at baseline and counseling should be addressed in every MO visit. If the patient is fully adherent, then counseling should be provided as necessary per the discretion of the practitioner.

To assure consistency, MO programs must develop written educational protocols in accordance with PHS standards that address (at minimum):

- Disease management
- HIV prevention
- Health maintenance
- Other treatment issues

STANDARD	MEASURE
Patient education about medical needs and treatment options should occur at every visit.	Record of education encounters on file in patient medical record.
Treatment adherence assessment should be provided in baseline.	• Notations in chart; initial assessment and progress notations.
Treatment adherence counseling should be provided in every visit, unless the patient is fully adherent.	Notations in chart; initial assessment and progress notations.
MO programs must develop written educational protocols in accordance with PHS standards.	Education protocols on file at provider agency that address (at minimum): • Disease management • HIV prevention • Health maintenance • Other treatment issues

PATIENT RECORDS

Patient records will be organized clearly and consistently by all MO providers. Records should be easily legible and follow a uniform format with a logical flow of information. Patient records will be kept in detail consistent with good medical and professional practice in accordance with the California Code of Regulations. Data should be entered in a timely fashion and be appropriately dated.

Records will include admission records, patient interviews, progress notes and a record of services provided by various clinical staff.

All clinical and health services records will be co-located in a "unit record" and include (at minimum):

- Documentation of HIV disease or AIDS diagnosis
- Complete medical, sexual and social history
- Completed physical examination and assessment signed by a licensed health care professional
- Differential diagnosis
- Current and appropriate treatment plan
- Current problem list
- Progress notes documenting patient status, condition and response to interventions, procedures and medications
- Documentation of all contacts with patient, including date, time, services, provided, referrals given and signature and title of person providing services

Patient unit records will also include the following documentation (at minimum):

- Specialty-specific assessment, diagnosis and treatment plan
- Documentation of special tests ordered
- Documentation of clinical assessments or diagnoses
- Documentation of health education and risk reduction activities
- Documentation of referrals and consults
- Documentation of patient education (risk reduction, treatment regimens, adherence, nutrition, health maintenance, etc.)
- Necessary patient and family contact information and identifiers
- Signed Consent to receive treatment and prevention services
- Signed Release of Information for each referral made
- Legible provider signatures
- Easily accessible quantitative viral measures, drug allergies and drug resistances
- Evidence of screening for patients at risk for TB, hepatitis or STDs
- Evidence of referral for health care maintenance and immunizations
- Evidence of service provider coordination activities
- Evidence of assessment for mental health and substance abuse services
- Evidence for the need of, referral to, or provision of, medical care coordination (e.g., MCC screen, assessment, and progress notes)

In addition, patient medical records shall include a notation of health maintenance activities appropriate for the care of people living with HIV including (but not limited to):

- Influenza vaccine
- Tetanus/diphtheria update
- Pneumovax
- Meningococcal vaccine for high-risk men who have sex with men (MSM) and those who request it
- Pap screening
- Hepatitis screening, vaccination
- TB screening
- Family planning
- Counseling on safer sex and STD screening
- Counseling on food and water safety
- Counseling on nutrition
- Harm reduction for alcohol and drug use

- Smoking cessation

STANDARD	MEASURE
Patient records will be kept in accordance with the California Code of Regulations.	Program review and monitoring to confirm.
Patient unit records will include: • Documentation of HIV disease or AIDS diagnosis • Medical, sexual and social history • Physical exam and assessment signed by licensed professional • Differential diagnosis • Current treatment plan • Current problem list • Progress notes • Documentation of all contacts with patient, including date, time, services, provided, referrals given and signature and title of person providing services Additional documentation including: • Specialty-specific assessment, diagnosis and treatment plan • Special tests • Clinical assessments or diagnoses • Health education and risk reduction activities • Referrals and consults • Patient education • Patient and family contact information and identifiers • Signed Consent for treatment and prevention services • Signed releases of information • Provider signatures • Viral measures, drug allergies and drug resistances • TB, hepatitis or STD screening • Coordination activities • Mental health and substance abuse service assessments • Referral to or provision of medical care coordination • Health care maintenance to include: • Influenza vaccine • Tetanus/diphtheria update • Pneumovax • Meningococcal vaccine for high-risk MSM and those who request it • Pap screening • Hepatitis screening, vaccination • TB screening • Family planning • Counseling on safer sex and STD screening • Counseling on food and water safety • Counseling on nutrition • Harm reduction for alcohol and drug use	Program review of patient unit records to confirm.

PATIENT RETENTION IN CARE

Programs will strive to retain patients in MO services. To ensure continuity of service and retention of patients, programs will be required to establish a broken 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 broken or failed appointments persists, patients must be referred to specialized adherence services and/or medical care coordination for support.

Medical Care Coordination staff should be involved in the identification and follow-up of patients who have fallen out of regular medical care.

STANDARD	MEASURE
Programs will develop a broken appointment policy to ensure continuity of service and retention of patients.	Written policy on file at provider agency.
Programs shall provide regular follow-up procedures to encourage and help maintain a patient in MO services.	Documentation of attempts to contact in signed, dated progress notes. Follow-up may include: • Telephone calls • Written correspondence • Direct contact
If broken or failed appointments persist, patients must be referred to specialized adherence services and/or medical care coordination.	Documentation of referral in patient record.

CASE CLOSURE

Case closure is a systematic process for disenrolling patients from medical outpatient-specialty 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.

Cases may be closed when the patient:

- Relocates out of the service area
- Has had no direct program contact in the past six months
- Is ineligible for the service
- No longer needs the service
- Discontinues the service
- Changes his or her primary care provider
- Is incarcerated long term
- Uses the service improperly or has not complied with the client services agreement
- Has died

STANDARD	MEASURE
MO programs will develop case closure criteria and procedures.	Case closure criteria and procedures on file at provider agency. Cases may be closed when the patient: • Relocates out of the service area • Has had no direct program contact in the past six months • Is ineligible for the service • No longer needs the service • Discontinues the service • Changes his or her primary care provider • Is incarcerated long term • Uses the service improperly or has not complied with the client services agreement • Has died
Programs will attempt to notify patients about case closure.	• Patient chart will include attempts at notification and reason for case closure.

STAFFING REQUIREMENTS AND QUALIFICATIONS

At minimum, all MO 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 www.thebodypro.com; HIV InSite at www.hivinsite.ucsf.edu; Johns Hopkins AIDS Service at www.hopkins-aids.edu; or, Medline Plus – AIDS at www.nlm.nih.gov/medlineplus/aids.html).

Programs will develop consultation protocols to assist MO 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 MO providers are expected to practice in accordance with applicable state and federal regulations, statutes and laws. MO practitioners must comply with codes of ethics and with any special HIV/AIDS policies from their respective national professional associations.

HIV MO services will be provided by a multidisciplinary team consisting of a primary care provider at the level of a state of California licensed physician, NP, and/or PA and an RN. The expanded team will 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.

STANDARD	MEASURE
MO 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.
MO 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

The following categories of health care professionals are approved to provide medical services in MO 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 vocational nurses (LVNs) may provide primary HIV nursing care services and medical care coordination.

STAFF QUALIFICATIONS

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

- **Physician HIV Specialist:** A physician (MD or DO) providing MO services must hold a valid license to practice medicine in the state of California (Medical Board of California or California Board of Osteopathic Examiners) 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 Public Health Service 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 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 MO services must have the following qualifications:
  - Licensure as an RN
  - An NP certificate or master's degree from a school accredited by the California Board of Registered Nursing
  - 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.

    To prescribe medicine, the NP must complete a pharmacology course and work six months under a physician's supervision and hold a DEA license.

    The NP works under the supervision of an HIV/AIDS specialist physician. Physician supervision must include regular chart review, as well as oversight of scheduled direct patient care. 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 California Board of Registered Nursing and the Medical Board of California. The NP must work within the scope of practice defined by Section 2834 Nurse Practitioner, California Code of Regulations 1435, 1470, and 1480 (www.rn.ca.gov/policies/pdf/npr-b-23.pdf).

- **PA HIV/AIDS Specialist:** A PA providing MO services must have graduated from a medical training program approved by the California Physician Assistant Committee, 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 by the Physician Assistant Committee, Department of Consumer Affairs' Medical Board of California, 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, see: www.physicianassistant.ca.gov.) The state-required 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 (www.physicianassistant.ca.gov/delegation.pdf). PAs authorized by supervising physicians to issue written "drug orders" for medication and medical devices must do so in compliance with the amended (January 1, 2000) Physician Assistant Practice Act (BPC, Section 3502.1).
- **Medical Specialists:** MO 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. MO 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.
- **RN:** An RN providing MO services must hold a license in good standing from the California State Board of Registered Nurses, be a graduate from an accredited nursing program with a Bachelor of Science in Nursing (BSN) or two year nursing associate's 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 California Business & Professional Code, Section 2725 RN Scope of Practice (www.rn.ca.gov).

STANDARD	MEASURE
Physicians (MD or DO) providing MO services hold state of California license (Medical Board of California or California Board of Osteopathic Examiners) 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.

STANDARD	MEASURE
NP HIV/AIDS specialists practitioners providing MO 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 be supervised by an HIV/AIDS specialist physician, including chart review and oversight of scheduled direct patient care. Programs will develop standardized procedures for medical functions performed by the NP.	Record of physician supervision on file at provider agency. NP standardized procedures on file at provider agency.
NPs must work within the scope of practice defined by Section 2834 Nurse Practitioner, California Code of Regulations 1435, 1470, and 1480.	Program review and monitoring to confirm.
PAs providing MO services must have: • Graduated from an approved medical training program • Passed the Physician Assistant National Certifying Examination (PANCE) • A license from the Physician Assistant Committee • A credential as an HIV/AIDS specialist, or have a credible plan to complete credential in one year	Resumes and verification of specialist and experience criteria on file at provider agency.
PAs must be supervised by an HIV/AIDS specialist physician, including chart review and oversight of scheduled direct patient care.	Record of physician supervision on file at provider agency.
PAs issuing drug orders must do so in compliance with the amended (January 1, 2000) Physician Assistant Practice Act (BPC, Section 3502.1).	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 MO services must: • Hold a license in good standing from the California State Board of Registered Nurses • Be a graduate from an accredited nursing program with a BSN or two-year nursing associate's 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's degrees) • Practice within the scope defined in the California Business & Professional Code, Section 2725	Resumes on file at provider agency to verify experience. Program review and monitoring to confirm.

EDUCATION AND LICENSING

Staff employed to provide MO services must maintain licenses by fulfilling the financial and continuing education requirements established by their respective professional state and national boards. MO practitioners must complete one accredited continuing educational

course addressing HIV/AIDS treatment adherence (for free local CEU sites see the AIDS Education and Training Center at www.aids-ed.org), one accredited course addressing HIV/AIDS clinical care management (for free local CEU sites see the AIDS Education and Training Center at www.aids-ed.org), and one accredited course in HIV/AIDS prevention, education and risk reduction (for free local CEU sites see the National Network of STD/HIV Prevention Training Centers at http://depts.washington.edu/nnptc) designed specifically for practitioners in MO settings. These requirements must be met annually for continued employment in the MO care program.

In selecting other continuing education courses to fulfill licensing requirements, MO 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.

STANDARD	MEASURE
MO staff must maintain licenses by completing continuing education requirements of their respective professional boards.	Record of continuing education in employee files at provider agency.
MO 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.

CERTIFICATIONS

MO practitioners requiring certification as an HIV/AIDS specialist must maintain this certification every two years as required by the regulations set by the American Academy of HIV Medicine.

Certification requirements include:

- Maintain current, valid MD, DO, PA or NP state license
- Provide direct, continuous care for at least 20 HIV patients over the past two years
- Complete at least 30 hours of HIV-related CME Category 1 credits over the past two years
- Successfully complete the HIV Medicine Credentialing Examination at time of application

The MO practitioners will comply with all additional certifications for health care staff required by the agency of employment and by their respective professional state boards. RNs are encouraged to pursue registered designation as an "AIDS Certified Registered Nurse" offered by the Association of Nurses in AIDS Care and the HIV/AIDS Nursing Certification Board (see: www.anacnet.org).

STANDARD	MEASURE
MO HIV/AIDS specialists must maintain certification every two years.	Record of certification in employee file at provider agency.
Other MO practitioners will comply with necessary certifications required by professional boards, etc.	Record of certification in employee file at provider agency.

STAFFING RATIOS

Physicians should maintain a doctor-to-patient ratio of not more than 1:1,500 if they do not supervise any NP or PA staff. Due to the amount of time the physician must devote to supervision, for clinics with NPs and PAs, the doctor-to-patient ratio declines for every additional supervision responsibility: it should not exceed 1:1,200 when a physician supervises one NP or PA staff person, 1:900 when supervising two NP and/or PA staff people, 1:600 when supervising three NP and/or PA staff people, and 1:300 when supervising four NP or PA staff people.

For each NP or PA, the ratio of medical professional-to-patients does not exceed 1:1,500.

STANDARD	MEASURE
Doctor-to-patient staffing ratios for physicians should be: • 1:1,500 with no supervisees • 1:1,200 with one NP/PA supervisee • 1:900 with two NP/PA supervisees • 1:600 with three NP/PA supervisees • 1:300 with four NP/PA supervisees	Program review and monitoring to confirm.
NP- or PA-to-patient ratio should not exceed 1:1,500.	Program review and monitoring to confirm.

ADDITIONAL OUTPATIENT STAFF—MEDICAL CARE COORDINATION

MEDICAL CARE MANAGERS

Medical care managers will be RNs in good standing and licensed by the California Board of Registered Nursing. An RN providing care coordination services must be a graduate of an accredited nursing program with a Bachelor of Science in Nursing (BSN) or two-year nursing associate's degree. The RN must practice within the scope of practice defined in the California Business & Professional Code, Section 2725 RN Scope of Practice (www.rn.ca.gov).

Medical care managers will practice in accordance with applicable state and federal regulations. Care managers will uphold the Code of Ethics for Nurses with Interpretive Statements (2001: ANA Board of Directors and Congress of Nursing Practice and Economics). Additionally, medical care managers will comply with special codes of ethics or HIV/AIDS policies from their national professional associations (see www.nursingworld.org for ANA Position Statements and www.anacnet.org for Policy Position Statements and Resolutions.)

PATIENT CARE MANAGERS

Patient care managers providing medical care coordination services will hold a Master of Social Work (MSW) degree or related master's degree (e.g., psychology, human services, counseling) from an accredited program. Patient care managers workers will practice in accordance with applicable state and federal regulations, uphold the Social Work Code of Ethics (http://www.naswdc.org/pubs/code/default.asp) and comply with the staff development and education requirements noted below.

CASE WORKERS

Case workers will hold one of the following (at minimum):

- A bachelor's degree in an area of human services
- A high school diploma (or GED equivalent) and at least one year's experience providing direct patient care in a related health services field

Case workers with medical specialty will be an LVN or certified medical assistant with at least one year's experience working in HIV care or have an LVN license and at least three years' experience providing direct patient care within a related health services field.

STANDARD	MEASURE
RNs providing medical care coordination services must: • Hold a license in good standing from the California State Board of Registered Nursing • Be a graduate from an accredited nursing program with a BSN or two year nursing associate's degree • Practice within the scope defined in the California Business & Professional Code, Section 2725	Resumes on file at provider agency to verify experience. Program review and monitoring to confirm.
Patient care managers providing medical care coordination services will: • Hold an MSW degree or related degree (psychology, human services, counseling) • Practice in accordance with applicable state and federal regulations, uphold the Social Work Code of Ethics (http://www.naswdc.org/pubs/code/default.asp) • Comply with the staff development and education requirements noted below	Resumes on file at provider agency to verify experience. Program review and monitoring to confirm.
Case workers will hold a bachelor's degree in an area of human services; a high school diploma or GED; and at least one year's experience providing direct patient care in a related health services field.	Resumes on file at provider agency to verify experience. Program review and monitoring to confirm.
Medical specialty case workers will be an LVN or certified medical assistant with at least one year's HIV experience or have an LVN license and at least three years' experience within a related health services field.	Resumes on file at provider agency to verify experience. Program review and monitoring to confirm.

MEDICAL NUTRITION THERAPY (OPTIONAL)

REGISTERED DIETITIAN

In addition to registration requirements, registered dietitians working in agencies or clinics that provide medical nutrition therapy will have the following:

- Broad knowledge of principles and practices of nutrition and dietetics
- Advanced knowledge in the nutrition assessment, counseling, evaluation and care plans of people living with HIV
- Advanced knowledge of current scientific information regarding nutrition assessment and therapy and the ability to distill and communicate this information to clients and other service providers

Registered dietitians will practice according to the code of ethics of the American Dietetic Association (found online at http://www.eatright.org/Public/index_8915.cfm).

Among the principles included in this code of ethics, a registered dietitian will:

- Practice dietetics based on scientific principles and current information
- Present substantiated information and interpret controversial information without personal bias; recognizing that legitimate differences of opinion exist
- Provide sufficient information to enable clients and others to make their own informed decisions
- Protect confidential information and make full disclosure about any limitations on his/her ability to guarantee full confidentiality
- Provide professional services with objectivity and with respect for the unique needs and values of individuals

Registered dietitians will participate in Dietitians in AIDS Care, maintain membership in the HIV/AIDS Dietetic Practice Group of the American Dietitian Association and complete current professional education (CPE) units/hours, primarily in HIV nutrition and other related medical topics as administered by the Commission on Dietetic Registration.

STANDARD	MEASURE
At minimum, all medical nutrition therapy staff will be able to provide appropriate care to people living with HIV, complete documentation as required by their positions and maintain appropriate licensure if applicable.	Staff resumes and qualifications on file at provider agencies.
Registered dietitians will have the following (at minimum): • Broad knowledge of principles and practices of nutrition and dietetics • Advanced knowledge in the nutrition assessment, counseling, evaluation and care plans of people living with HIV • Advanced knowledge of current scientific information regarding nutrition assessment and therapy	Staff resumes, qualifications and records of training on file at provider agencies.
Registered dietitians will practice according to their code of ethics.	Performance review to confirm.
Registered dietitians will maintain membership in the HIV/AIDS Dietetic Practice Group.	Record of membership in employee file.
Registered dietitians will maintain current professional education (CPE) units/hours, primarily in HIV nutrition and other related medical topics as administered by the Commission on Dietetic Registration.	Training record in employee file.

UNITS OF SERVICE

Unit of Service: Units of service defined as reimbursement for medical outpatient-specialty services provided to eligible patients as defined below.

- ***Diagnostic, preventive and therapeutic medical service units:*** calculated in number of 45-minute intakes and 15-30 minute follow-up sessions provided
- ***ENT specialty care:*** calculated in number of visits or evaluations, or by Current Procedural Terminology (CPT) code for procedures
- ***Oncology specialty care:*** calculated in number of visits or evaluations, or by CPT code for procedures
- ***Ophthalmologic specialty care:*** calculated in number of visits or evaluations, or by CPT code for procedures
- ***Syphilis serology screening units:*** calculated in number of tests provided
- ***Viral resistance testing units (genotypic and phenotypic):*** Calculated in number of tests provided
- ***Gastrointestinal specialty care:*** calculated in number of visits or evaluations, or by CPT code for procedures
- ***Neurological and neurosurgery specialty care:*** calculated in number of visits or evaluations, or by CPT code for procedures
- ***Colorectal specialty care:*** calculated in number of visits or evaluations, or by CPT code for procedures
- ***Dermatological specialty care:*** calculated in number of visits or evaluations, or by CPT code for procedures
- ***Pulmonary specialty care:*** calculated in number of visits or evaluations, or by CPT code for procedures

- ***Surgical specialty care:*** calculated in number of visits or evaluations, or by CPT code for procedures
- ***Urology specialty care:*** calculated in number of visits or evaluations, or by CPT code for procedures
- ***Orthopedic, endocrinology, cardiology, nephrology and other specialty care:*** calculated in number of visits or evaluations, or by CPT code for procedures
- ***Specialized TB treatment:*** calculated in number of visits or evaluations, or by CPT code for procedures
- ***Treatment adherence assessments:*** calculated in number of assessments
- ***Medical care coordination units:*** calculated in number of patient visits
- ***Nutrition screening units:*** calculated in number of screenings
- ***Health education and risk reduction counseling units:*** calculated in number of counseling and education sessions
- ***Counseling and referral for sex partners and affiliates units:*** calculated in number of counseling sessions

Number of Patients: Patient numbers are documented using the figures for unduplicated patients within a given contract period.

MEDICAL OUTPATIENT-SPECIFIC PROGRAM REQUIREMENTS

TB SCREENING

All MO care program staff, other program employees, volunteers, and consultants who have routine, direct contact with clients living with HIV must be screened annually for tuberculosis. Programs are directed to the TB Control Program at 2615 S. Grand Avenue in Los Angeles 90007 (Phone 213-744-6151) for more information.

STANDARD	MEASURE
All MO staff, volunteers and consultants with routine, direct patient contact must be screened for TB.	Record of TB screening for staff, volunteers and consultants on file at provider agency.

OCCUPATIONAL POSTEXPOSURE PROPHYLAXIS (PEP)

MO programs must develop policies and procedures to address the risks for occupational HIV and hepatitis exposure. Programs should aggressively promote and monitor risk reduction behaviors and actively support MO primary care professionals in PEP. Reports for occupationally acquired HIV should be made to Division of Healthcare Quality Promotion at 800-893-0485. Programs and practitioners are directed to the National Clinician's PEP Hotline at 800-448-4911 or www.ucsf.edu/hivcntr; and the Hepatitis Hotline: 888-443-7232 or www.cdc.gov/hepatitis for more information.

STANDARD	MEASURE
MO programs must develop policies and procedures concerning HIV and hepatitis exposure.	Exposure policies and procedures on file at provider agency.
Reports of occupational HIV exposure must be made to Division of Healthcare Quality Promotion.	Record of reports on file at provider agency.

STATE-MANDATED HIV REPORTING

Consistent with the State Health and Safety Code (Section 2643.5), all MO practitioners are mandated to report laboratory test results that indicate HIV, a component of HIV, or antibodies to or antigens of HIV. Within seven calendar days of receipt of a confirmed HIV test and partial non-name code from a laboratory, MO practitioners must complete an HIV/AIDS Case Report Form using the non-name code (as specified in Section 2641.75) and report the HIV case to the County HIV Epidemiology Program, unless previously reported by the practitioner.

STANDARD	MEASURE
MO practitioners will report positive HIV test results to LA County Epidemiology Program.	Copies of HIV/AIDS Case Report form using non-name code on file at provider agency.

PATIENT/STAFF/COLLEAGUE COMMUNICATION

Agencies must develop written policies and procedures to address communication between MO staff, patients and other professionals to include a protocol for colleagues, social service professionals, patients, partners, family members or other supportive persons to contact staff for emergencies, holidays and weekends.

STANDARD	MEASURE
MO programs must develop policies and procedures to address communication between staff, patients, family members and other professionals, including emergency contact provisions.	Communication policies and procedures on file at provider agency.

TRANSLATION/LANGUAGE INTERPRETERS

Federal and state language access laws (Title VI of the Civil Rights Act of 1964 and California's 1973 Dymally-Alatorre Bilingual Services Act) require health care facilities that receive federal or state funding to provide competent interpretation services to limited English proficiency (LEP) patients at no cost, to ensure equal and meaningful access to health care services. MO programs must develop procedures for the provision of such services, including the hiring of staff able to provide services in the native language of LEP patients.

STANDARD	MEASURE
MO programs must develop policies and procedures to address the provision of competent interpretation services to LEP patients at no cost.	Interpretation policies and procedures on file at provider agency.

POLICY AND PROCEDURE MANUAL

All MO programs will develop and maintain a written policy and procedure manual which will include mandatory policies, procedures, protocols and standards of care related to the following (at minimum):

- Coordination of care with other providers, including specialty care, case management, mental health, treatment education, inpatient care, etc.

- Patient hospitalization arrangements
- Home health care for patients whose health status warrants, including mechanisms for coordination of care between primary caregivers, inpatient providers and home care providers
- Referral processes to support services as needed

STANDARD	MEASURE
MO programs must develop policies and procedures manual to address mandatory policies, procedures, protocols and standards	Policies and procedures manual on file at provider agency that addresses (at minimum): • Coordination of care • Patient hospitalization • Home health care • Referrals to support services

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANA	Association of Nurses in AIDS Care
ARV	Antiretroviral
BSN	Bachelor of Science in Nursing
BUN	Blood Urea Nitrogen
CBC	Complete Blood Count
CDC	Centers for Disease Control and Prevention
CD4	Cluster Designation 4
CDHS	California Department of Health Services
CEU	Continuing Education Units
CME	Continuing Medical Education
CPE	Current Professional Education
CPT	Current Procedural Terminology
DEA	Drug Enforcement Administration
DHHS	Department of Health and Human Services
DHSP	Division of HIV and STD Programs
DNR	Do Not Resuscitate
DO	Doctor of Osteopathy
ENT	Ear, Nose and Throat
FQHC	Federally Qualified Health Care
GC	Gonorrhea Chlamydia
GED	General Education Development
GI	Gastrointestinal
HCSUS	Heath Cost Services and Utilization Study
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
IGRA	Interferon Gamma Release Assay
ISP	Individual Service Plan
JCAHO	Joint Committee on Accreditation of Healthcare Organization
LOA	Letters of Agreement

LVN	Licensed Vocational Nurse
MCC	Medical Care Coordination
MO	Medical Outpatient
MSM	Men Who Have Sex with Men
MSW	Master of Social Work
NCCPA	National Commission on Certification of Physician Assistants
NP	Nurse Practitioner
OB/GYN	Obstetrics/Gynecology
PANCE	Physician Assistant National Certifying Examination
PA	Physician's Assistant
PCRS	Partner Counseling and Referral Services
PEP	Postexposure Prophylaxis
PHS	Public Health Service
POLST	Physician's Orders for Life Sustaining Treatment
PPC	Prevention Planning Committee
PPD	Purified Protein Derivative
PrEP	Preexposure Prophylaxis
RN	Registered Nurse
RNA	Ribonucleic Acid
SIL	Sildenafil
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infections