Comments on Outpatient Ambulatory Medical Care

Standards

#	Location	Comment	DSHS Response	Discussion	Determination
1	p. 2 Provider/Agency will conduct peer review for all levels of providers (i.e. MD, NP, PA).	Is this relevant for agencies that have clinics on site only? If not, we have no way of conducting peer reviews. We do still go over and staff clients with Dr. Verner (medical director at WMCPHD), Dr Flowers who supervises the residents, the residents and Laurel and myself. Their social worker comes in sometime.	Each of the providers providing HIV care should be participating in a peer review process whether they work in a clinic or in private practice.		
2	p. 3 2nd row, right column under Lifestyle near bottom	Consider adding something like: "Nutrition – quality and quantity of daily food and liquid intake" as another general history item to be assessed	Agree will add		
3	p. 4 - Comprehensive History	Asterisks indicate things I have not seen provider documentation on. -Travel history and place of birth * -Complementary and alternative therapies to include supplements/herbs * -Pets/animal exposures*	These items are recommended in the HIV Guidelines for Clinical Care http://hab.hrsa.gov/deliverhivaidscare/2014guide.pdf		

		Spirituality*			
4	p. 4-9 (Exams, testings, screenings)	Have these been updated to include any more specific/appropriate for our Aging HIV client populations? (our growing numbers of clients age 50+ have some different and unique medical/social/etc. factors, versus younger client groups)	Aging HIV patients are faced with the same diseases as older patients without HIV; mainly chronic diseases. There is a section asking providers to assess for chronic diseases. The psychosocial/laboratory tests would apply to patients of all ages. Is there something more you would like to see in the Standards?		
5	Pg. 5 CXR	Currently our clinic performs chest x-rays when it is deemed medically necessary. We believe the implementation of routine initial chest x-rays would not be to the benefit of the patient. Unnecessary exposure to radiation would is not ideal for our patients. Additionally, our clinic does not have on-site access to an x-ray machine or x-ray technicians. This would require patients to get this service through referral. We recommend that this standard we revised to be as-needed.	Agree; will reword to include when deemed necessary.		
6	p 6 Screenings	Please add T-spot to TB tests that can be used.	Will change wording to Tuberculin Skin Test (TST)		

7	p. 7 Anal Pap	We currently do not offer Anal Pap Tests; though we would like to. Our current staff lacks the training to be able to implement this level of screening. It would be beneficial if DSHS could provide direct training for staff to be able to do Anal Pap tests – If DSHS cannot provide the training, additional training funds would be beneficial. An additional barrier to implementing this screening is that there is only one provider in Austin where patients can be referred for follow up procedure.	This is a recommendation from the HIV Clinical guidelines April 2014. We encourage the AA to work with AETC on providing training for providers. Since this item is a recommendation, this item will remain in the standards and on the monitoring tool but will not be monitored in 2015.		
8	p. 7 MMR	We do not keep this vaccine onsite as it is a live vaccine. When needed, patients are referred out for the MMR vaccine. We suggest that this recommendation be revised reflect that vaccines can be provided through appropriate referrals.	Agree, will add wording for referral.		
9	p. 11 Treatment Adherence	Most providers address clients taking meds and document compliancy, but I have never seen a tool that was used to do the assessment.	The Viral Suppression workgroup is working on identifying a tool		

10	p. 11 Treatment Adherence	I've never seen documentation where a doctor referred clients for adherence counseling if they were not compliant.	What is currently being done then for additional support?		
11	p. 12 Referral If CD4 count below 50 cells/mm^3 should be referred for ophthalmic examination by a trained retinal specialist for screening or as recommended by that specialist.	We refer patients; however, if they are not funded they may not be seen. The current wait is one year for specialty clinics.	Referral is the key word in this item.		
12	p. 14 Documentation	Problems are identified by providers and addressed individually but they do not have a prioritized the list.	Agree -- will take out the word prioritized.		
13	p. 15 Missed appointments	I have on occasion seen documentation of missed appts but no follow-up is documented in notes.	Providers should be encouraged to conduct follow-up on those out of care.		
14	p. 15 Missed appointments	Primary contact with patients is conducted over the phone. Use of US Mail is limited due to patient preference and possible issues with confidentiality. Email is not a preferred method of contact because many of our patients access email though	We need to discuss during the conference call		

		public venues such as the library, which would pose an issue for confidentiality.			
15	General	We need to include instructions to document in electronic and hard copy file. – Or will there be something separate for ARIES?	There will be a separate document on the minimum elements required to be documented in ARIES. We are requiring the monitors to review the primary client/patient recording system for information.		
16	NOTE: Early Intervention Services provided by Ryan White Part C and Part D Programs should be included here	Take out duplicate	Oops -- will do!		
17	p. 2 All agency staff, contractors, and consultants who provide direct-care services, and who require licensure, shall be properly licensed by the State of Texas, or documented to be pursuing	What is the difference between "shall be properly licensed"…"or documented to be pursuing Texas licensure while performing tasks that are legal within the provisions of the Texas Medical Practice Act"? Do they need to be licensed or not?	Some physicians can practice in Texas in a limited capacity and under certain circumstances prior to being licensed.		

	Texas licensure while performing tasks that are legal within the provisions of the Texas Medical Practice Act				
18	p. 2 All staff without direct experience with HIV/AIDS shall be supervised by one who has such experience.	For how long?	This needs to be written in either a AAs policy or an agency policy as to what competencies are needing to be met before direct supervision can end.		
19	p. 12 Patients will have at least one medical visit in each 6-month period with a minimum of 60 days between the first medical visit in prior 6-month period and last medical visit in the subsequent 6-month period.	Possible simplification: Patients will have at least one medical visit in each 6-month period with a minimum of 60 days between each period.	This is HRSA wording; therefore cannot be reworded. DSHS will be providing a diagram to assist monitors in assessing whether this item has been met.		

20	p. 14 Contact patients who have missed appointments using at least 3 different forms of contact (email, phone, mail, home visit)	Could this be 3 calls to 3 different numbers? Does it have to be 3 different forms of contact?	Will need to discuss during the conference call		
21	p. 14 Contact patients who have missed appointments using at least 3 different forms of contact (email, phone, mail, home visit)	Not sure if a home visit is really appropriate with OAMC.	The intent of this item is to bring patients back into care; not to provide OAMC services in the home. We encourage referrals to case management or DIS as they do conduct home visits.		
22	p. 14 Documentation of Missed Appointments Contact patients who have missed appointments using at least 3 different forms of contact (email, phone, mail, home visit)	Three different forms of contact isn't feasible. Most agencies are not allowed to email or make home visits. Recommend changing standard to two forms of contact.	Will need to discuss during the conference call		