

## Miami-Dade County Ryan White Program

### Minimum Primary Medical Care Standards for Chart Review

#### Medical Care Subcommittee Miami-Dade HIV/AIDS Partnership

**Statement of Intent:** All Ryan White Program funded practitioners are required by contract to adhere, at a minimum, to the Public Health Service (PHS) Guidelines.

1. **Requirements for Practitioners** (Physicians, Nurse Practitioners, and Physician Assistants):

- Practitioner must be a Physician (MD or DO), Nurse Practitioner, or Physician Assistant with current and valid license to practice medicine within the State of Florida
- Practitioners must have a minimum of three years of experience treating HIV clients or have served a high volume (50) of HIV+ clients in the past year
- Practitioners are strongly encouraged to complete at least 30 hours of HIV-related Continuing Medical Education (CME) Category 1 credits within a period of two years. When a new practitioner is working with a contracted practitioner, new practitioner is encouraged to comply within one year.
- Treat and monitor patients in adherence with current DHHS Guidelines and other standards of care, to include, but not limited to:
  - a. DHHS Clinical Guidelines  
<http://www.aidsinfo.nih.gov/Guidelines/>
  - b. American Cancer Society Guidelines for the Early Detection of Cancer  
[http://www.cancer.org/docroot/PED/content/PED\\_2\\_3X\\_ACS\\_Cancer\\_Detection\\_Guidelines\\_36.asp](http://www.cancer.org/docroot/PED/content/PED_2_3X_ACS_Cancer_Detection_Guidelines_36.asp)
  - c. European AIDS Clinical Society (EACS) guidelines on the prevention and management of metabolic diseases in HIV  
<http://www.ncbi.nlm.nih.gov/pubmed/18257770>
  - d. Lipid Disorders subset of the AIDS Education and Training Centers  
[http://www.faetc.org/PDF/15th Annual/Advanced Track/Finals for Handouts/Managing Multiple Diseases/Orrick Handout MMD dyslipidemia.pdf](http://www.faetc.org/PDF/15th%20Annual/Advanced%20Track/Finals%20for%20Handouts/Managing%20Multiple%20Diseases/Orrick%20Handout%20MMD%20dyslipidemia.pdf)
  - e. CDC Recommended Adult Immunization Schedule  
<http://www.cdc.gov/vaccines/recs/schedules/downloads/adult/2009/adult-schedule-11x17.pdf>
  - f. Incorporating HIV Prevention into the Medical Care of Persons Living with HIV  
<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5212a1.htm>
- Follow an action plan to address any areas for improvement that are identified during quality assurance reviews

## ***Minimum Standards of Which Practitioners Will Be Measured***

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### **Assessments and Referrals**

2. **Initial** – At initial visit
  - a. Comprehensive initial history
  - b. Physical examination, including review of systems
  - c. Vital signs, including weight
  - d. Gynecological exam including pap smear and pelvic for females
  - e. Rectal examination and stool guaiac testing
  - f. Sexual transmitted infection assessment
  - g. Age appropriate cancer screening
  - h. Adherence to medications
  - i. Risk reduction (including safer sex practices)
3. **Interim Monitoring and Problem-Oriented visits** - At every visit:
  - a. Vital signs, including weight
  - b. Physical examination related to specific problem, as appropriate
  - c. Interval changes in vital signs addressed, especially trend in weight over time
  - d. Adherence to medications
  - e. Risk reduction (including safer sex practices)
4. **Annual** – At each annual visit:
  - a. Update comprehensive initial history, as appropriate
  - b. Physical examination, including review of systems
  - c. Vital signs, including weight
  - d. Interval changes in vital signs addressed, especially trend in weight over time
  - e. Gynecological exam including pap smear and pelvic for females
  - f. Rectal examination and stool guaiac testing
  - g. Sexual transmitted infection assessment
  - h. Age appropriate cancer screening
  - i. Adherence to medications
  - j. Risk reduction (including safer sex practices)

### **Assessments to be included at Incremental Visits**

5. **Gynecological Exam**<sup>i ii</sup> (females), including Pap smear and pelvic - Starting at 3 years post sexual activity onset or at age 21, at initial evaluation, or upon entry to prenatal care, and another Pap smear 6 months later. If both smears are negative, annual screening is recommended thereafter in asymptomatic women. More frequent screenings recommended - every 6 months - for women with symptomatic HIV infection, prior abnormal Pap smears, or signs of HPV infection
6. **Mammogram**<sup>iii</sup> (females) - Starting at age 40, screening recommended annually
7. **Colon and Rectal Cancer Screening**<sup>v</sup> - Colorectal cancer screening recommended for individuals starting at age 50. For those with several first-degree relatives who had prostate cancer at an early age, this discussion should take place at age 40. If unable to perform or if patient refuses, a fecal occult blood test (FOBT)<sup>iv</sup> should be performed every year. For FOBT used as a screening test, the take-home multiple sample method should be used. A

FOBT done during a digital rectal exam in the practitioner's office is not adequate for screening

8. **Purified Protein Derivative (PPD)<sup>y</sup>** - QuantiFERON TB Gold or Tuberculin Skin Test (TST), placed by the Mantoux method, should be performed as close to diagnosis of HIV infection and annually thereafter. If tested when CD4 < 200, repeat after CD4 increases to above 200. Annual PPD is recommended if patient is deemed high risk (repeated or ongoing exposure to known active TB, after incarceration, after living in congregate setting, active drug user or other risk factor for TB). If PPD positive or has had active Tuberculosis documented with adequate treatment, annual chest X-ray should be performed. If chest X-ray cannot be afforded, cough screen questionnaire may be used as suggested by David Ashkin, MD
9. **Assess annually and document health education on:**
  - a. Nutritional assessment/care
  - b. Oral health care
  - c. Mental Health assessment/care
  - d. Exercise
  - e. Drugs/Alcohol/Tobacco (including smokeless) assessment/care
  - f. Domestic violence
  - g. Birth control
  - h. Advance Directives (completion or review)
10. **Additional Charting/Documentation:**
  - a. Problem list complete and up-to-date
  - b. Medications list complete with start and stop dates, dosages
  - c. Allergies list complete and up-to-date
  - d. Immunization list complete and up-to-date

## Laboratory

11. **CD4 T-cell count<sup>ii</sup>** - entry into care, follow-up before ART every 3-6 months, ART initiation or switch, treatment failure, or if clinically indicated. For patients documented as adherent with suppressed HIV Viral Load and stable clinical and immunologic status for > 2-3 years, can extend interval monitoring to every 6 months
12. **HIV RNA<sup>ii</sup>** - entry into care, follow-up before ART every 3-6 months, ART initiation or switch, 2-8 weeks post-ART initiation, treatment failure, or if clinically indicated. For patients documented as adherent with suppressed HIV Viral Load and stable clinical and immunologic status for > 2-3 years, can extend interval monitoring to every 6 months
13. **Resistance testing<sup>ii</sup>** - entry into care, ART initiation or switch, treatment failure, or if clinically indicated. For treatment-naïve patients, if resistance testing was performed at entry into care, repeat testing is optional post-ART initiation; for patients with viral suppression who are switching therapy for toxicity or convenience, resistance testing will not be possible and therefore, is not necessary. Genotype conducted at entry into care, prior to start of antiretroviral (ARV) therapy and when failing therapy (HIV viral load  $\geq$  1,000)
14. **HLA-B\*5701<sup>ii</sup>** - If considering start of abacavir and document in record carrying data forward to most current volume

15. **Tropism testing**<sup>ii</sup> – If considering use of CCR5 antagonist (HIV viral load must be  $\geq 1000$ ) or if clinically indicated. If performed, record carried forward to most current volume
16. **Basic chemistry**<sup>ii</sup> - entry into care, follow-up before ART every 6-12 months, ART initiation or switch, 2-8 weeks post-ART initiation, or if clinically indicated. Serum Na, K, HCO<sub>3</sub>, Cl, BUN, creatinine, glucose (preferably fasting). It is suggested to monitor phosphorus while on tenofovir; determination of renal function should include estimation of creatinine clearance using Cockcroft & Gault equation<sup>vii</sup> or estimation of glomerular filtration rate based on MDRD equation
17. **ALT, AST, T. bili, D. bili**<sup>ii</sup> - entry into care, follow-up before ART every 6-12 months, ART initiation or switch, 2-8 weeks post-ART initiation, or if clinically indicated
18. **CBC w/ differential**<sup>ii</sup> - entry into care, follow-up before ART every 3-6 months, ART initiation or switch, 2-8 weeks post-ART initiation if a zidovudine-containing regimen, or if clinically indicated
19. **Fasting Lipid Profile**<sup>ii</sup> (12 hours fasting) – entry into care, follow-up before ART annually if normal, ART initiation or switch, consider 2-8 weeks post-ART initiation, every 6 months if abnormal or borderline at last measurement, every 12 months if normal at last measurement, or if clinically indicated
20. **Fasting Glucose**<sup>ii</sup> (12 hours fasting) – entry into care, follow-up before ART annually if normal, ART initiation or switch, every 3-6 months if abnormal or borderline at last measurement, every 6 months if normal at last measurement, or if clinically indicated
21. **Urinalysis**<sup>ii</sup> - entry into care, at time of ART initiation or change, every 6 months in patients with HIV-associated nephropathy, and every 12 months in patients on a tenofovir-containing regimen, or if clinically indicated<sup>viii</sup>
22. **Pregnancy test**<sup>ii</sup> (females) – if starting an efavirenz-containing regimen or if clinically indicated
23. **Hepatitis A Screening**<sup>ix</sup> - At initial screening, Hepatitis A total antibody (HAVAb) or IgG (not IgM). Unless Hepatitis C infected, may consider administering immunization when CD4 cell count greater than 200 cells/mm<sup>3</sup>
24. **Hepatitis B Screening**<sup>vi</sup> - At initial screening, Hepatitis B core antibody (HBcAb) total or IgG (not IgM), Hepatitis B surface antibody (HBsAb), and Hepatitis B surface antigen (HBsAg). If HBsAg is positive, evaluate Hepatitis B Viral Load by DNA PCR, and obtain Hep Be Ag and Ab
25. **Hepatitis C Screening**<sup>vi</sup> - At initial screening, Hepatitis C antibody (HCVAb). If HCVAb is positive evaluate Hepatitis C (HCV) Viral Load, genotype, and include treatment plan in record; If negative and active Injection Drug User or other HCV risk factor, repeat HCVAb in 12 months; If there is an unexplained chronic LFT elevation, Hepatitis C viral load should be evaluated (even if HCVAb is negative)

26. **Syphilis, N. gonorrhoeae (GC), C. trachomatis (Chlamydia)**<sup>x</sup> - Screening should be performed at least annually for all sexually active patients, more frequently might be appropriate depending on individual risk behaviors, the local epidemiology of STDs, and whether incident STDs are detected by screening or by the presence of symptoms. For men who have sex with men (MSM) via Receptive anal intercourse - screen for rectal gonorrhea and Chlamydia. For men who have sex with men (MSM) via receptive oral intercourse - screen for pharyngeal gonorrhea (Chlamydia not recommended). For men who have sex with men (MSM) with multiple or anonymous partners, or have sex during , illicit drug use, or use methamphetamine, or have sex partners with these risk factors, screening is recommended at 3-6 month intervals.<sup>xi</sup> Assume that all adult patients are sexually active unless noted in history or progress note that patient denies being sexually active
27. **Prostate-specific antigen (PSA) Screening**<sup>xii</sup> (males) - Offered annually, beginning at age 50, to men who have at least a 10-year life-expectancy. For African American men and those with a first-degree relative (father, brother, son) who had prostate cancer at an early age (< 65y/o), this discussion should take place at age 45. For those with several first degree relatives with prostate cancer at an early age, screening should begin at age 40. Information should be provided to all men about what is known and what is uncertain about the benefits, limitations, and harms of early detection and treatment of prostate cancer so that they can make an informed decision about testing.

### Immunizations/Treatments

28. **Influenza vaccination**<sup>xi</sup> - Offer TIV annually and document in record
29. **Pneumococcal polysaccharide (PPSV) vaccination**<sup>xi</sup> - Offer initial vaccination as close to HIV diagnosis as possible, and then 1 booster after 5-6 years. Document in record carrying data forward to most current volume
30. **Hepatitis A vaccination**<sup>xi</sup> - Offer vaccination if not immune. Assess for response 30 days after vaccination by performing Hep A antibody IgG or Hep A Total antibody. Document in record carrying data forward to most current volume
31. **Hepatitis B vaccination**<sup>xi</sup> - Offer vaccination if not immune. Double dose is recommended. Assess for response 30 days after vaccination by performing Hepatitis B surface antibody quantitative (Hep B SAb Quant). Document in record carrying data forward to most current volume
32. **Tetanus, diphtheria, pertussis (Td/Tdap)**<sup>xiii</sup> - Substitute 1-time dose of Tdap, for adults age 19-64 who have not received a dose of Tdap previously, for Td booster; then boost with Td every 10 yrs. Document in record carrying data forward to most current volume
33. **ARV therapy is considered and discussed** - If offered, the risks and benefits are discussed
34. **Treatment of opportunistic infections and prophylaxis for opportunistic infections** - specifically, but not limited to, Mycobacterium avium complex (MAC), Pneumocystis Carinii Pneumonia (PCP), and Toxoplasmosis (Toxo) prophylaxis per DHHS Guidelines<sup>xiv</sup>

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<sup>i</sup> Routine pelvic examination and cervical cytology screening. ACOG Committee Opinion No. 431. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2009;113:1190–3.

<sup>ii</sup> <http://www3.niaid.nih.gov/topics/HIVAIDS/Understanding/Population+Specific+Information/womenHiv.htm> Accessed July 22, 2009.

<sup>iii</sup> [http://www.cancer.org/docroot/PED/content/PED\\_2\\_3X\\_ACS\\_Cancer\\_Detection\\_Guidelines\\_36.asp](http://www.cancer.org/docroot/PED/content/PED_2_3X_ACS_Cancer_Detection_Guidelines_36.asp). Accessed July 21, 2009.

<sup>iv</sup> [http://my.clevelandclinic.org/services/fecal\\_occult\\_blood\\_test/hic\\_fecal\\_occult\\_blood\\_test.aspx](http://my.clevelandclinic.org/services/fecal_occult_blood_test/hic_fecal_occult_blood_test.aspx). Accessed July 22, 2009.

<sup>v</sup> Adult Prevention and Treatment of Opportunistic Infections Guidelines Working Group. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents. March 24, 2009. *MMWR* 2009; 58 (early release) pp 1-198. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr58e324a1.htm>. Accessed July 21, 2009.

<sup>vi</sup> Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. November 3, 2008; 1-139. Available at <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>. Accessed July 21, 2009. Page 6, Table 3.

<sup>vii</sup> <http://www.clinicalcalculator.com/english/nephrology/cockroft/cca.htm>. Accessed July 22, 2009.

<sup>viii</sup> For patients with renal disease, consult “Guidelines for the Management of Chronic Kidney Disease in HIV-Infected Patients: Recommendations of the HIV Medicine Association of the Infectious Diseases Society of America” (*Clin Infect Dis* 2005; 40: 1559-85).

<sup>ix</sup> <http://www.aidsetc.org/pdf/workgroups/pcare/pcwg-heptools.pdf>. Accessed July 21, 2009.

<sup>x</sup> *Counseling for Patients with HIV Infection and Referral to Support Services*, page 18, *Sexually Transmitted Diseases Treatment Guidelines, 2006*, <http://www.cdc.gov/MMWR/PREVIEW/MMWRHTML/rr5511a1.htm>. Accessed July 21, 2009

<sup>xi</sup> <http://www.faetc.org/PDF/Newsletter/Newsletter-Volume10-2009/HIVCareLink-Vol10-Issue-5-April-15.pdf>. Accessed July 22, 2009.

<sup>xii</sup> [http://www.cancer.org/docroot/PED/content/PED\\_2\\_3X\\_ACS\\_Cancer\\_Detection\\_Guidelines\\_36.asp](http://www.cancer.org/docroot/PED/content/PED_2_3X_ACS_Cancer_Detection_Guidelines_36.asp).

Accessed July 21, 2009.

<sup>xiii</sup> <http://www.cdc.gov/vaccines/recs/schedules/downloads/adult/2009/adult-schedule-11x17.pdf>. Accessed July 22, 2009.

<sup>xiv</sup> Adult Prevention and Treatment of Opportunistic Infections Guidelines Working Group. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents. March 24, 2009. *MMWR* 2009; 58 (early release) pp 1-198. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr58e324a1.htm>. Accessed July 21, 2009.