Outpatient Ambulatory Health Services

Service Definition

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

OAHS must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

Subrecipients providing OAHS are expected to comply with the Universal Standards of Care, as well as these additional standards:

Standard 1: Providers of OAHS must ensure services are delivered in accordance with the Wisconsin Ryan White Part B Eligibility and Recertification Policy and Procedures.

Providers are responsible for determining eligibility at enrollment and for confirming eligibility annually.

Documentation

Client records must document that the client is living with HIV, resides in Wisconsin, and has household income under 500% FPL at initial enrollment in accordance with the Wisconsin Ryan White Part B Eligibility Policy, linked above.

Standard 2: The delivery of OAHS is provided in an outpatient setting for allowable services.

Only allowable services are provided. Allowable services include:

- Diagnostic testing.
- Early intervention and risk assessment.
- Preventative care and screening.
- Practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions.
- Prescribing and managing of medication therapy.
- Education and counseling on health issues.
- Well-baby care.
- Continuing care and management of chronic conditions.
- Referral to and delivery of HIV-related specialty care.

To be allowable, the service cannot be provided in an emergency room, inpatient unit, or any other type of inpatient treatment center.

Documentation

The client record must contain documentation that allowable services were provided in an outpatient setting.

Standard 3: The delivery of OAHS must be consistent with guidelines and recommendations from the U.S. Department of Health and Human Services (HHS) and the Infectious Disease Society of America (IDSA).

The treatment and management of HIV-related conditions through the provision of outpatient Ambulatory services must be consistent with HHS Clinical Guidelines for Treatment of HIV/AIDS and IDSA Practice Guidelines.

Medical providers of OAHS must be familiar with and generally follow such guidelines and recommendations.

Documentation

Medical providers of OAHS must provide care in accordance with HHS and IDSA guidelines under most circumstances. Any deviations from these guidelines must be justified by specific client circumstances and/or evidence-based medical practices.

Standard 4: Access to HIV OAHS or primary medical care is provided in a timely manner.

OAHS medical providers must follow policies and procedures that facilitate timely, medically appropriate care.

Medical providers are encouraged to understand the benefits of timely initial clinic visits and rapid initiation of antiretroviral therapy in newly diagnosed patients. Medical providers are encouraged to demonstrate scheduling flexibility to accommodate newly diagnosed patients.

Patients with acute symptoms should have immediate same-day telephone access to, at minimum, Registered Nurses (RN) to assess symptoms to determine the urgency and level of care needed to triage the response. Medical providers are encouraged to have planned availability for urgent visits based on the need in their patient population.

Documentation

Subrecipient policies and procedures must specify how emergent, urgent, and acute needs of new and established patients are managed.

Standard 5: Intakes are conducted in a safe, welcoming, and trauma-informed way.

Medical and non-medical providers or non-service provider staff who conduct intake services must create a safe, welcoming, and trauma-informed environment for all new clients to encourage retention in services.

Documentation

Medical and non-medical providers or non-service provider must be able to describe clinic policies, protocols, and practices that create an environment to build client rapport.

Standard 6: Providers of OAHS systematically assess retention of clients in care and implement clinic practices that encourage retention.

A pattern of missed or canceled appointments can lead to gaps in medical care services and may be related to underlying challenges or barriers to care. Providers should address this systematically and proactively, to promote continuity of care for all clients.

Understanding that people living with HIV (PLWH) face multiple barriers to care, clinics should, as often as possible, develop approaches that accommodate patients who arrive late for appointments or miss them. This may include building in clinic time for late-arriving patients or urgent care needs, offering video or telehealth visits, or weekend and drop-in hours.

Subrecipients must develop a policy that outlines procedures to follow up, as soon as possible, when clients do not attend scheduled appointments, to encourage retention in care.

Documentation

Subrecipients must have a written policy on file at the provider agency regarding retention in care and missed or canceled appointments. This policy should include a clear plan for clients who are "lost to follow-up."

Documentation of attempts to contact clients at risk of loss-to-care must be included in client records. Follow-up may include telephone calls, written correspondence, direct contact, or other technological means, such as text messaging or email.

Standard 8: When a client needs a translator or interpreter, the subrecipient must make a certified medical interpreter available to the client.

Subrecipients must have available and offer certified medical interpreter services to clients. A client's family members and friends should not be considered as interpreters due to medical technology limitations and should only be considered as interpreters if the client refuses services of a certified medical interpreter.

Subrecipients should proactively inform clients that medical interpretation services are available.

Documentation

Subrecipients must maintain a current contract with a provider of certified medical interpreter services or maintain medical interpretation certifications of staff employed by the clinic. If the client refuses the use of a certified medical interpreter, the client record must include documentation of client refusal.

Standard 9: Voluntary patient transitions to other providers are seamless and emphasize uninterrupted access to care, whenever possible.

When patients express an intent to transfer their OAHS to another provider, this transition should be handled with courtesy and professionalism.

Whenever possible, all transition of records should happen within 30 days of request and should include all items requested by the patient and the provider, within the limits of HIPAA and other laws, regulations, and policies.

Documentation

Subrecipients must document how its protocols, policies, and practices regarding voluntary transfers emphasize uninterrupted access to care.

A medical provider, non-medical provider, or other non-service provider staff member must document steps taken to transfer care to another HIV outpatient ambulatory health service provider and why the transfer occurred in the client record.

Standard 10: Subrecipients establish and apply criteria by which clients will be transferred to other OAHS providers without client request.

There may be time when clients need to be transferred to other providers for a variety of reasons, including client behavior that poses a threat to clinic staff and clients.

Each subrecipient must establish criteria and processes for such transfers and apply it consistently, while still attempting to prevent interruptions in care.

Documentation

The clinic must document how its protocols, policies, and practices regarding involuntary transfers emphasize uninterrupted access to care.

Standard 11: Subrecipients must establish criteria for client discharge while encouraging re-engagement in OAHS.

Clients may be discharged from OAHS for reasons that include, but are not limited to:

- Completion of the treatment plan.
- Voluntary withdrawal from the service.
- Death of the client.
- Relocation outside of the service area.
- Failure of client to attend appointments and failure to respond to correspondence for an extended time.

- Severe, inappropriate, threatening, or otherwise destructive behavior on the part of the client that makes continuation of services dangerous to the provider or unlikely to be helpful to the client.

Unless contraindicated, providers should attempt to convey that ongoing medical care is extremely important, and that the provider would be open to re-engagement in care in the future.

Documentation

The clinic must document how its protocols, policies, and practices regarding case closure are reasonable and attempt to motivate the client to re-engage in medical care.

Did you know?

Seventy-seven percent of all Ryan White Part B clients in Wisconsin accessed Outpatient/Ambulatory Health Services in 2023.

On Wisconsin's HIV Care Continuum, in 2022, White people were more likely to be in care as compared to both Black or African American people and Latinx or Hispanic people (88% vs. 82% and 82%), and more likely to be virally suppressed (82% vs. 73% and 77%).

Addressing health disparities and inequities is a priority for public health. Race or ethnicity does not make someone more or less likely to acquire HIV. Many social and economic factors affect populations of color more than White populations in Wisconsin, including racism, poverty, stigma, homelessness, oppression, limited access to health care, and lack of education.

Sources: Wisconsin HIV Surveillance Annual Report, 2022, available at: https://www.dhs.wisconsin.gov/publications/p00484-22.pdf.

HIV-related stigma creates unnecessary barriers and affects the health and wellbeing of people living with HIV. Misconceptions about HIV and lack of accurate and up-to-date knowledge contribute to stigma and can keep people from getting tested and accessing resources, treatment, and services. Prioritizing reducing stigma looks like offering support, speaking out against stereotypes and myths, and ensuring intersectional perspectives are valued and appreciated.
Source: Wisconsin Integrated HIV Prevention and Care Plan 2022–2026, available at: https://www.dhs.wisconsin.gov/publications/p03516.pdf.
