Outpatient/Ambulatory Health Services
Service Standard

Health Resources & Service Administration (HRSA) Description: Outpatient/Ambulatory Health Services (OAHS) provide diagnostic and therapeutic-related activities directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings may include: clinics, medical offices, mobile vans, using telehealth technology, and urgent care facilities for HIV-related visits.

Program Guidance: Treatment adherence activities provided during an OAHS visit are considered OAHS services, whereas treatment adherence activities provided during a medical case management visit are considered medical case management services.

Limitations: Non-HIV related visits to urgent care facilities are not allowable costs under OAHS per HRSA RWHAP PCN 16-02. Emergency room visits are not allowable costs within the OAHS category.

Services: Allowable activities include:
- Medical history taking
- Physical examination
- Diagnostic testing (including HIV confirmatory and viral load testing), as well as laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription, and management of medication therapy
- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis, including audiology and ophthalmology

Care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies (ART).

Diagnostic laboratory testing includes all indicated medical diagnostic testing, including all tests considered integral to treatment of HIV. Funded tests must meet the following conditions:
- Tests must be consistent with medical and laboratory standards as established by scientific evidence and supported by professional panels, associations, or organizations;
- Tests must be (1) approved by the U.S. Food and Drug Administration (FDA), when required under the FDA Medical Devices Act; and/or (2) performed in an approved Clinical Laboratory Improvement Amendments of 1988 (CLIA)-certified laboratory or State-exempt laboratory; and
- Tests must be (1) ordered by a registered, certified, or licensed medical provider, and (2) necessary and appropriate based on established clinical practice standards and clinical judgment.

*Telehealth and Telemedicine* is an alternative modality to provide most Ryan White Part B and State
Services funded services. For the Ryan White Part B/SS funded providers and Administrative Agencies, telehealth & telemedicine services are to be provided in real-time via audio and video communication technology which can include videoconferencing software.

DSHS HIV Care Services requires that for Ryan White Part B or SS funded services providers must use features to protect ePHI transmission between client and providers. RW Providers must use a telehealth vendor that provides assurances to protect ePHI that includes the vendor signing a business associate agreement (BAA). Ryan White Providers using telehealth must also follow DSHS HIV Care Services guidelines for telehealth and telemedicine outlined in [DSHS Telemedicine Guidance](#)
### Service Standard and Measure

The following Standards and Measures are guides to improving clinical care throughout the State of Texas within the Ryan White Part B and State Services Program. The most current U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Guide for HIV/AIDS Clinical Care – 2014 Edition are sources cited throughout the Standards for additional reference materials for direct care service providers.

<table>
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<th>Standard</th>
<th>Measure</th>
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| **Comprehensive HIV-related history:** Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. Providers should document a comprehensive HIV-related history that is inclusive of all components listed in the OAHS Standard as referenced in the HHS guidelines. This can be completed during the initial visit or divided over the course of two or three early visits. History shall consist of, at a minimum, general medical history, a comprehensive HIV related history, and psychosocial history to include:  
  • Documented past medical and surgical history with regard to chronic diseases such as diabetes, high blood pressure, heart disease, cholesterol, asthma or emphysema, sickle cell disease, etc. per HHS guidelines.  
  • Psychosocial history to include socio-cultural assessment, occupational history, hobbies (as applicable), travel history, mental health, and housing status.  
  • Lifestyle including tobacco use, alcohol use, illicit substance use, exercise, travel history.  
  • Sexual Health including partners, practices, past sexually transmitted infections (STIs), contraception use (past and present).  
  • HIV-related health history including most recent CD4 and Viral Load results, current ART (if applicable), previous adverse ART drug reactions, history of HIV-related illness and infections, HIV treatment history and staging. |
| Percentage of patients with a documented comprehensive HIV-related history that is inclusive of all components listed in the OAHS Standard as referenced in the HHS guidelines. |


| Physical examination: Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. Providers should perform a baseline and annual comprehensive physical examination, with attention to areas potentially affected by HIV. Physical examination will include the documentation from the complete review of systems as indicated within the comprehensive medical history. | Percentage of patients with a documented annual physical examination. 
Percentage of patients with a diagnosis of HIV who received an oral cavity exam during the physical exam as documented in the patient’s primary record. |
|---|---|

Laboratory tests, as clinically indicated by licensed provider: Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. Tests will include as clinically indicated:

- HIV Antibody, if not documented previously;
- CD4 Count and/or CD4 Percentage
- Quantitative Plasma HIV RNA (HIV Viral Load)
- HIV Viral Load Suppression
- Standard genotypic drug-resistance testing (Refer to Table 3 in the “Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV” for guidance on other scenarios where genotype testing is recommended)
- Coreceptor Tropism Test (if considering use of CCR5 co-receptor antagonist or for patients who exhibit virologic failure on a CCR5 antagonist)
- HLA-B*5701 testing (only before initiating abacavir-containing regimen per guidelines)
- Complete Blood Count (CBC) with Differential and Platelets
- Chemistry Profile: Electrolytes, Creatinine, Blood Urea Nitrogen (BUN)
- Liver Transaminases, Bilirubin (Total and Direct)
- Urinalysis with Urine Protein and Creatinine
- Lipid Profile – random or non-fasting (Total Cholesterol, LDL, HDL, Triglycerides)
- Glucose (random or non-fasting) or hemoglobin A1C
- Hepatitis A antibody, Hepatitis B surface antigen, core Ab, and surface antibody & Hepatitis C antibody screens at initial intake (providers should screen all HIV-infected patients for anti-HCV antibodies at baseline)
  - Quantitative HCV RNA viral load testing (for Hepatitis C (HCV) positive patients who are candidates for treatment)
- Toxoplasma gondii IgG
- Pregnancy Test (for female clients of childbearing potential)
- RPR or treponemal antibody (Syphilis Screening)
- Gonorrhea (GC) and Chlamydia (CT) Testing
- Trichomoniasis Testing


| Percentage of patients with documented laboratory tests completed according to the OAHS Standard and HHS treatment guidelines. |
| Percentage of patients with documented CD4 count (absolute). |
| Percentage of patients with documented HIV-RNA viral load. |
| Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year. *(HRSA HAB Measure)* |
| Percentage of patients, regardless of age, with a diagnosis of HIV who had an HIV drug resistance test performed before initiation of HIV ART if therapy started during the measurement year. *(HRSA HAB Measure)* |
| Percentage of patients, regardless of age, with a diagnosis of HIV who were prescribed HIV ART and who had a random or fasting lipid panel during the measurement year. *(HRSA HAB Measure)* |
| Percentage of patients with a diagnosis of HIV at risk for STIs who had a test for chlamydia within the measurement year. *(HRSA HAB Measure)* |
| Percentage of patients with a diagnosis of HIV at risk for STIs who had a test for gonorrhea within the measurement year. *(HRSA HAB Measure)* |
| Percentage of adult patients with a diagnosis of HIV who had a test for syphilis performed within the measurement year. *(HRSA HAB Measure)* |
| Laboratory tests, as clinically indicated by licensed provider (continued) | Hepatitis B screening was performed at least once since the diagnosis of HIV or for whom there is documented infection or immunity. *(HRSA HAB Measure)*  
Percentage of patients for whom HCV screening was performed at least once since the diagnosis of HIV. *(HRSA HAB Measure)*  
Percentage of patients with a Hepatitis C RNA viral load test, as applicable, completed within the measurement year. |
|---|---|
| **Other diagnostic testing:** Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines.  
Chest x-ray will be completed if pulmonary symptoms are present; if positive LTBI test (either TST or Interferon Gamma Release Assay (IGRA)); or if prior evidence of LTBI or pulmonary TB (perform annually). | Percentage of patients with documented chest x-ray completed if pulmonary symptoms were present, after an initial positive (IGRA); after initial positive TST, or annually if prior evidence of LTBI or pulmonary TB. |
| **Screenings/Assessments:** Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. Patients should receive screening for opportunistic infections and assessment of psychosocial needs initially and annually according to the most current HHS guidelines. Screening should include at a minimum:  
- Mental health assessment that includes screening for clinical depression (PHQ 2 at a minimum)  
- Psychosocial assessment, including domestic violence and housing status (housing status noted as: stable housing, unstable housing, or homeless)  
- Substance use and abuse screening  
- Tobacco use screening  
- Pediatric patients (14 years and younger) will be screened for child abuse as defined in Chapter 261 of the Texas Family Code and DSHS policy. Consider screening youth 14-17 for child abuse.  
- Oral health exam and assessment  
- Tuberculosis (TB) Screening | Percentage of patients with documented medical screenings and assessments as indicated in the OAHS Standard and in accordance with HHS guidelines.  
Percentage of female patients with a diagnosis of HIV who were screened for cervical cancer in the last three years. *(HRSA HAB Measure)*  
Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool. *(DSHS revised - HRSA HAB Measure)*  
Percentage of patients aged 12 years and older with positive clinical depression screen with follow-up plan documented on the date of the positive screen. *(DSHS revised - HRSA HAB Measure)* |

### Screenings/Assessments (continued):

- **Cervical Cancer Screen (following the most current clinical recommendations)**
  - **Women Aged <30 Years** with HIV:
    - If younger than age 21, known to have HIV or newly diagnosed with HIV, and sexually active, Pap test should be performed within one (1) year of onset of sexual activity regardless of mode of HIV transmission.
  - **Women Aged >30 Years** with HIV:
    - Pap test should be done at baseline and every 12 months. If results of three (3) consecutive Pap tests are normal, follow-up Pap tests can be performed every three (3) years.

- **Anal Cancer (Dysplasia) Screening**: The Anal Cancer (Dysplasia) Screening Guidelines recommend, at a minimum, annual digital examination to detect masses on palpation that could be anal cancer. However, performing the digital exam alone as a screening procedure for anal dysplasia or cancer will miss many lesions. Anal cancer screening using a Pap test can improve sensitivity for detecting anal dysplasia or cancer. Cytology combined with high-resolution anoscope (HRA) is considered the best strategy for screening of precancerous lesions. If anal Pap is performed, clinicians should refer patients with abnormal anal cytology for HRA. In communities where HRA is not available, clinicians should consider referring patients with abnormal anal cytology to a surgeon for evaluation.


**Cervical Cancer Screen**
**Immunizations:** Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines.

Immunizations/vaccinations will be given according to the most current HHS guidelines and the CDC’s “Table 2: Recommended Adult Immunization Schedule by Medical Condition and Other Indications, US 2020.” See: [https://www.cdc.gov/vaccines/schedules/hcp/imz/adult-conditions.html](https://www.cdc.gov/vaccines/schedules/hcp/imz/adult-conditions.html) Providers will initiate prophylaxis for specific opportunistic infections.

Patients will be offered vaccinations for the following:

- Tetanus, Diphtheria, and Pertussis (Tdap) per recommended treatment guidelines for immunizations
- Measles, Mumps, Rubella (MMR) per recommended treatment guidelines for immunizations. **Adults and adolescents with a CD4 cell count <200 cells/μL should not receive MMR.**
- Influenza (inactivated vaccine)- annually during flu season October 1st - March 31st
- Pneumococcal is recommended for all patients, **two separate vaccines are recommended;**
  - Receive a dose of PCV13, *(Prevnar 13)*, followed by a dose of PPV23 *(Pneumovax)* at least eight (8) weeks later.
- Completion of Hepatitis B (HBV) vaccines series, unless otherwise documented as immune, **vaccinated patients should be tested for HBsAb response 1–2 months after completed the series or at the next scheduled clinic visits after completing the series.**
- Completion of Hepatitis A (HAV) vaccines series, unless otherwise documented as immune.
- Varicella-Zoster (VZV): Please reference current treatment guidelines. **This vaccination is contraindicated in persons with HIV and CD4 count <200.**

*HPV vaccine: The 2019 *Advisory Committee on Immunization Practices* (ACIP) recommends and DHHS states: “because of the potential benefit in preventing HPV-associated disease and cancer in this population, HPV vaccination is recommended for HIV infected males and females aged 11 through 26, but can be initiated as early as 9 years of age. For persons 27-45, ACIP recommends a conversation between provider and client regarding vaccine for this age group.

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**Percentage of patients with Tetanus, Diphtheria, and Pertussis current within 10 years, Td booster doses every 10 years thereafter, or documentation of refusal.**

**Percentage of patients aged six months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization OR documentation of refusal.** *(DSHS Revised - HRSA HAB Measure)*

**Percentage of patients with a diagnosis of HIV who completed the vaccination series for Hepatitis A, or documentation of refusal.**

**Percentage of patients with a diagnosis of HIV who ever received pneumococcal vaccine, or documentation of refusal.**

**Percentage of patients with a diagnosis of HIV who ever received the Zoster vaccine, or documentation of refusal.**

**Percentage of patients with a diagnosis of HIV between the ages of 11 and 26 years (can be initiated as early as 9 years of age) who completed the series for HPV, or documentation of refusal.**
**Anti-retroviral Therapy (ART):** Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. ART will be prescribed in accordance with the HHS established guidelines. Patients who meet current guidelines for ART are offered and/or prescribed ART.


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<tr>
<th>Percentage of patients, regardless of age, with a diagnosis of HIV are prescribed antiretroviral therapy (ART) for the treatment of HIV during the measurement year. <em>(HRSA HAB Measure)</em></th>
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**Health Education/Risk Reduction:** Health education will adhere to the most current HHS guidelines. Providers will provide routine HIV risk-reduction counseling and behavioral health counseling for HIV-infected patients.

Since patients’ behaviors change over time as the course of their disease changes and their social situations vary, health education providers will tailor routine risk-reduction counseling and behavioral health counseling not only to the individual patient but also to the point in time in the patient’s life.

The following will be conducted initially and as needed:

- Providers should discuss safer sexual practices so to decrease risk of transmitting HIV.
- Providers should counsel HIV-infected patients about the risk of acquiring syphilis and other STIs from unprotected sexual contact, including all sites of possible transmission, such as anus, cervix, vagina, urethra, and oropharynx.
- Providers should discuss family planning with patients
- Contraception counseling/hormonal contraception
- Drug interaction counseling
- Providers should counsel patients on tobacco cessation annually for those patients that were screened and positive for smoking (or document decline of tobacco use)
- When current alcohol or other substance use is identified, providers should discuss the possible effects of such use on the patient’s general health and HIV medications, as well as options for treatment if indicated
- Providers should routinely discuss with patients the importance of disclosure to partners. Patients should be educated about the options for voluntary partner notification.
- When HIV patients are diagnosed with early syphilis (primary, secondary, or early latent), providers should intensify risk-reduction counseling, including discussions about the importance of condom use.

<table>
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<tr>
<th>Percentage of patients with a diagnosis of HIV who received HIV risk counseling in the measurement year. <em>(HRSA HAB Measure)</em></th>
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<th>Percentage of patients aged 18 years and older who received cessation counseling intervention if identified as a tobacco user. <em>(DSHS Revised - HRSA HAB Measure)</em></th>
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<th>Percentage of patients with documented counseling about family planning method appropriate to patient’s status, as applicable, to include preconception counseling.</th>
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<th>Percentage of patients with documented instruction regarding new medications, as appropriate.</th>
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<th>Percentage of patients with documented counseling regarding the importance of disclosure to partners.</th>
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### Health Education/Risk Reduction (continued): The following will be conducted initially and as needed (continued):

- **Nutritional Counseling regarding:**
  - Quality and quantity of daily food and liquid intake
  - Exercise (as medically indicated)

**Sources:**

### Treatment Adherence: Assessment of treatment adherence and counseling will be provided that adheres to current HHS guidelines. Patients are assessed for treatment adherence and counseling at a minimum of twice a year. Those who are prescribed on-going ART regimen must receive adherence assessment and counseling on every HIV-related clinical encounter. If adherence issue is identified by another member of the healthcare team (MCM, MA, LVN, RN), there is documented evidence of adherence counseling and follow-up action. This adherence counseling documentation must be evident in the patient’s medical record and clearly indicated that the prescribing provider was made aware of the adherence issue.


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<th>Percentage of patients with documented assessment for treatment adherence two or more times within the measurement year if patient is on ART.</th>
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<tr>
<td>Percentage of patients with documented adherence issues who received counseling for treatment adherence two or more times within the measurement year.</td>
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<tr>
<td>Percentage of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits. <em>(HRSA HAB Measure)</em></td>
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<tr>
<td>Percentage of patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year. <em>(HRSA HAB Measure)</em></td>
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**Referrals:** Providers will refer to specialty care or other systems as appropriate in accordance with current HHS guidelines. At a minimum, patients should receive referrals to specialized health care/providers/services as needed or medically indicated to augment medical care:

- AIDS Drug Assistance Program (ADAP)
- Medication Assistance Programs
- Medical care coordination
- Medical specialties
- Mental health and substance use services -Treatment education services
- Partner counseling and referral
- Annual oral hygiene and intraoral examinations, including dental caries and soft-tissue examinations
- Medical Nutrition Therapy (MNT)
- Health maintenance, as medically indicated, such as:
  - Cervical Cancer Screening
  - Family Planning
  - Colorectal cancer screening
  - Breast cancer screening
- Specialty medical care for any preexisting chronic diseases
- Case Management Services or a Disease Investigation Specialist (DIS) for follow-up if missing appointments.
- Vision Care
- Audiology

Providers/staff are expected to follow-up on each referral to assess attendance and outcomes. For specific details regarding screening modalities and timeframes see The United States Preventive Services Task Force

https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results?topic_status=P

**Source:** Page 10-11, 73; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf

**Percentage of patients, as medically indicated, who had documentation of referrals for:**

- Mental Health and/or Substance Use
- Oral Health
- Ophthalmological services
- Child abuse if suspected abuse
- Disease intervention specialist
- Other specialty services.

**Percentage of patients with a documented referral in the measurement year, has a progress note in the patient’s chart regarding attendance, and outcomes of the referral.**
### Documentation in Patients’ Medical Chart

Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. Clinicians (included but not limited to Providers with prescriptive authority, PharmD, PhD, LCSW, LCDC, RN, LVN, MA or MCM) will develop/update plan of care at each visit.

If a patient refuses a treatment, such as vaccinations, documentation of denial will be written in the patient's medical chart.

The provider developing the plan will sign each entry, an electronic signature is allowable.


### Documentation of missed patient appointments and efforts to bring the patient into care.

Provider and/or staff will conduct the following:
- Contact patients who have missed appointments, using at least 3 different forms of contact (phone, mail, emergency contact, phone call, referral to DIS for home visit) prior to determining they are lost to follow-up;
- Address any specific barriers to accessing services;
- Document number of missed patient appointments and efforts to bring the patient into care.


### Percentage of patient medical records with signed clinician entries.

### Percentage of flow sheets present and updated in the patient medical records.

### Percentage of problem lists present and updated in the patient medical records.

### Percentage of medication lists present and updated in the patient medical records.

### Percentage of patient medical records with documentation of any specific barriers and efforts made to address missed appointments.
**Perinatally Exposed Infants: Neonatal Zidovudine (ZDV) Prophylaxis**

All newborns perinatally exposed to HIV should receive postpartum antiretroviral (ARV) drugs to reduce the risk of perinatal transmission of HIV. Newborn ARV regimens—at gestational-age-appropriate doses—should be initiated as close to the time of birth as possible, preferably within 6 to 12 hours of delivery.

The selection of a newborn ARV regimen should be determined based on maternal and infant factors that influence risk of perinatal transmission of HIV. The uses of ARV Regimens in Newborns include:

- **ARV Prophylaxis**: The administration of one or more ARV drugs to a newborn without documented HIV infection to reduce the risk of perinatal acquisition of HIV.
- **Empiric HIV Therapy**: The administration of a three-drug ARV regimen to newborns at highest risk of perinatal acquisition of HIV. Empiric HIV therapy is intended to be preliminary treatment for a newborn who is later documented to have HIV but also serves as prophylaxis against HIV acquisition for those newborns who are exposed to HIV *in utero*, during the birthing process, or during breastfeeding and who do not acquire HIV.
- **HIV Therapy**: The administration of a three-drug ARV regimen at treatment dosages (antiretroviral therapy [ART]) to newborns with documented HIV infection.

Providers with questions about ARV management of perinatal HIV exposure should consult the National Perinatal HIV Hotline (1-888-448-8765), which provides free clinical consultation on all aspects of perinatal HIV, including newborn care.

All newborns with perinatal exposure to HIV should receive antiretroviral (ARV) drugs in the neonatal period to reduce perinatal transmission of HIV, with selection of the appropriate ARV regimen guided by the level of transmission risk.

- The most important factors that influence the risk of HIV transmission to a newborn exposed to HIV are whether the mother has received antepartum/intrapartum antiretroviral therapy (ART) and her viral load.
- The risk of transmission is increased in the absence of maternal ART or if maternal antepartum/intrapartum treatment was started after early pregnancy or was ineffective in producing virologic suppression; higher maternal viral load, especially in later pregnancy, correlates with higher risk of transmission.

There is a spectrum of transmission risk that depends on these and other maternal and infant factors, including mode of delivery, gestational age at delivery, and maternal health status. HIV transmission can occur *in utero*, intrapartum, or during breastfeeding.

Drug selection and dosing considerations are related to the age and gestational age of the newborn. Consultation is available through the National Perinatal HIV Hotline (888-448-8765).

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**Percentage of infants born to HIV + women who were prescribed ZDV prophylaxis for HIV within 12 hours of birth during the measurement year.**

*(HRSA HAB Measure)*
Diagnostic Testing to Exclude HIV Infection in Exposed Infants.

**Newborns Born to Mothers Who Received Antepartum/Intrapartum Antiretroviral Drugs with Effective Viral Suppression:** According to US Department of Health and Human Services, (DHHS) the risk of HIV acquisition in newborns born to women who received ART regimens during pregnancy and labor and had undetectable viral loads at delivery is <1%.

- DHHS recommends a 4-week neonatal zidovudine prophylaxis regimen for newborns if the mother has received ART during pregnancy with viral suppression (usually defined as confirmed HIV RNA level below the lower limits of detection of an ultrasensitive assay) at or after 36 weeks’ gestation, and there are no concerns related to maternal adherence.

**Newborns Born to Mothers with Unknown HIV Status at Presentation in Labor**

- Expedited HIV testing is recommended during labor for women with unknown HIV status and, if not performed during labor, as soon as possible after birth for the mothers and/or their newborns (see Identification of Perinatal Exposure). Expedited test results should be available within 60 minutes.
- If maternal or infant expedited testing is positive, the newborn should be immediately initiated on a multi-drug ARV prophylaxis regimen or empiric HIV therapy, without waiting for the results of supplemental tests.
- Expedited HIV testing should be available on a 24-hour basis at all facilities with a maternity service and/or neonatal intensive care unit or special care or newborn nursery.
- A nursing mother who is suspected of having HIV based on an initial positive antibody or antibody/antigen test result should stop breastfeeding until HIV is confirmed or ruled out.
- Breastfeeding is not recommended for women with confirmed HIV in the United States, including those receiving ART.

**Newborns Born to Mothers with Antiretroviral Drug-Resistant Virus**

- The optimal ARV regimen for newborns delivered by women with ARV drug-resistant virus is unknown. The ARV regimen for newborns born to mothers with known or suspected drug resistance should be determined in consultation with a pediatric HIV specialist before delivery or through consultation via the National Perinatal HIV Hotline (888-448-8765).
- Data exist to provide dosing recommendations appropriate for the treatment of HIV in neonates.

References


MMWR (January 31, 2014 / 63(04); 69-72) CDC Grand Rounds: Reducing the Burden of HPV- Associated Cancer and Disease available https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6304a1.htm


Recommended Immunization Schedule for Adults Aged 19 Years or Older. United States. 2020 Advisory Commission on Immunization Practices (ACIP), Table 1. https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html


Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance.shtm

Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services – Users Guide and FAQs, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance-faq.shtm