Outpatient/Ambulatory Health Services Service Standard

Texas Department of State Health Services, HIV Care Services Group — HIV/STD Program | Texas DSHS

Subcategories	Service Units
Acute Care Visit	Per visit
CD-4 T-Cell Count	Per test
Dermatology	Per visit
Developmental Assessment for Infants/Children	Per visit
Developmental Intervention for Infants/Children	Per visit
Infectious Disease	Per visit
Intravenous (IV) Administration	Per visit
Laboratory Service	Per test
Neurology	Per visit
Obstetrics/Gynecology	Per visit
Oncology	Per visit
Ophthalmology	Per visit
Other Specialty	Per visit
Outpatient/Ambulatory Health Services	Per visit
Radiology	Per test
Telemedicine Services	Per visit
Vaccine Administration	Per visit
Viral Load Test	Per test

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.

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).

Program Guidance:

Treatment adherence activities provided during an OAHS visit are OAHS services, whereas treatment adherence activities provided during a Medical Case Management visit are Medical Case Management services.

Limitations:

Non-HIV-related visits to urgent care facilities and emergency room visits are not allowable costs under OAHS per HRSA Ryan White HIV/AIDS Program Policy Clarification Notice (PCN) 16-02.

Per Ryan White HIV/AIDS Program Policy Notice 07-02, diagnostic and laboratory testing provided under OAHS 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.

Agencies should follow Texas Medicaid policies to determine the appropriateness of contact lenses and contact lens-related appointments:

- Contact lenses may be considered for clients of any age if there is no other option available to correct or ameliorate a visual defect.
- Contact lenses are limited to once every 24 months. Additional services within the 24-month period may be considered when documentation in the client's medical record supports medical necessity for a diopter change of 0.5 or more in the sphere, cylinder, prism measurement(s), or axis changes. A new 24-month benefit period for eyewear begins with the placement of the new non-prosthetic eyewear.
- Clients receiving contacts must have a provider's written documentation supporting the need for contact lenses as the only means of correcting the vision defect.

Universal Standards:

Service providers for Outpatient/Ambulatory Health Services must follow HRSA and DSHS Universal Standards 1-54.

Primary Care Service Standards and Measures:

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. Standards are based on federally approved guidelines, including the 2023 Health and Human Services (HHS) HIV clinical guidelines and the HRSA Guide for HIV/AIDS Clinical Care – 2014 Edition. Guidelines also link to additional sources where applicable. Clinical knowledge is continuously evolving, and providers should deliver care in accordance with the most recent available guidelines. The Primary Care Service Standards and Measures are applicable when OAHS is used to provide primary HIV care services. For specialty care, see the Specialty Care Service Standards and Measures.

Standard	Measure

Comprehensive HIV-related History: Providers will conduct a comprehensive health history that includes detailed HIV-related information and all relevant medical, psychosocial, and family history. This can be completed during the initial visit or divided over the course of two or three early visits. Providers should request and review medical records from previous treatment to supplement self-reported history and update the medical record accordingly. At a minimum, this health history will include:
• History of Present Illness and HIV-specific history, including:
  ○ Diagnosis and testing history
  ○ Prior HIV care, including current and past ART
  ○ CD4 and viral load history
  ○ History of any HIV-related illness
• Past medical and surgical history, including:
  ○ Chronic conditions and comorbidities
  ○ Gynecological and obstetric history, as applicable
  ○ Sexual health history
  ○ Immunizations
• Psychosocial history, including:
  ○ Mental health history
	1. Percentage of clients with a documented comprehensive HIV-related history that is inclusive of all components listed in the OAHS Standard.

○ Social history ○ Current and past use of substances ○ Travel history, if applicable • Family history **Sources:** Page 61-70, Guide for HIV/AIDS Clinical Care - 2014 Edition Section II, Primary Care Guidance for Persons With Human Immunodeficiency Virus: 2020 Update by the HIV Medicine Association of the Infectious Diseases Society of America (idsociety.org)	
Physical examination: Providers should perform a baseline and annual comprehensive physical examination, with attention to areas potentially affected by HIV. **Sources:** Page 73-77; Guide for HIV/AIDS Clinical Care - 2014 Edition Section II, Primary Care Guidance for Persons With Human Immunodeficiency Virus: 2020 Update by the HIV Medicine Association of the Infectious Diseases Society of America (idsociety.org)	2. Percentage of clients with a documented annual physical examination.
Laboratory Tests: Providers should follow the most recent HHS guidelines, which contain detailed recommendations on laboratory tests for initial assessment and treatment monitoring, including appropriate testing intervals. A licensed provider should order all tests, which may include, as clinically indicated: • Confirmatory HIV testing, if not documented previously • CD4 count and CD4 percentage • Quantitative plasma HIV RNA (HIV viral load) • Genotypic drug-resistance testing before or at the time of initiation of antiretroviral therapy (refer to HHS guidelines for guidance on other scenarios where resistance testing is recommended). *ART initiation should not be*	3. Percentage of clients who had an HIV drug resistance test performed before or at the time of initiation of ART, if therapy started during the measurement year. (*HRSA HAB measure*) 4. Percentage of clients with documented CD4 count (absolute).

delayed pending the results of resistance testing. • Coreceptor tropism test (if considering use of CCR5 co-receptor antagonist or for clients who exhibit virologic failure on a CCR5 antagonist) • HLA-B*5701 testing (only before initiating abacavir-containing regimen) • CBC with differential and platelets • Metabolic panel • Liver transaminases and bilirubin (total and direct) • Urinalysis with urine protein and creatinine • Lipid profile (random or fasting) • Glucose (random or fasting) • Hepatitis A antibody, hepatitis B serology (surface antigen, core antibody, and surface antibody), and hepatitis C antibody screens at initial intake, and when otherwise clinically indicated • Quantitative hepatitis C virus (HCV) viral load testing (for clients with hepatitis C who are candidates for treatment) • Pregnancy test (for clients of childbearing potential) • RPR, VDRL, or treponemal testing (syphilis screening) • Gonorrhea (GC) and chlamydia (CT) testing at all applicable sites • Trichomoniasis testing for clients with a vagina **Sources:** Adult and adolescent laboratory monitoring: Tests for Initial Assessment and Follow-up | NIH (hiv.gov) Pediatric laboratory monitoring: Clinical and laboratory monitoring of pediatric HIV infection | NIH Drug resistance testing: Drug-Resistance Testing | NIH (hiv.gov) STI testing recommendations: STI Screening Recommendations (cdc.gov)	5. Percentage of clients with documented HIV-RNA viral load. 6. Percentage of clients with a documented complete blood count (CBC) with differential and platelets within the measurement year. 7. Percentage of clients with a documented basic or comprehensive metabolic panel (BMP or CMP) during the measurement year. 8. Percentage of clients who were prescribed ART and who had a random or fasting lipid panel at least once since diagnosis of HIV. (*DSHS-revised HRSA HAB measure*) 9. Percentage of clients at risk for sexually transmitted infections (STIs) who had gonorrhea testing at all applicable sites within the measurement year. (*DSHS-revised HRSA HAB measure*) 10. Percentage of clients at risk for STIs who had chlamydia testing at all applicable sites within the measurement year. (*DSHS-revised HRSA HAB measure*) 11. Percentage of adult clients who had a test for syphilis performed within the

	measurement year (*HRSA HAB measure*) 12. Percentage of clients, regardless of age, for whom hepatitis A total antibody screening was performed at least once since the diagnosis of HIV or for whom there is documented infection or immunity. 13. Percentage of clients, regardless of age, for whom 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*) 14. Percentage of clients for whom hepatitis C screening was performed at least once since the diagnosis of HIV. (*HRSA HAB measure*) 15. Percentage of clients with a hepatitis C viral load test, as applicable, completed within the measurement year.
Screenings and Assessments: Providers should conduct routine preventative health services, screening for opportunistic infections as applicable, and assessment of psychosocial needs initially and annually. For detailed information on screening modalities and timelines, refer to the United States Preventative Taskforce (see source list). Screening should include at a minimum: • Mental health assessment with an age-appropriate, standardized screening for clinical depression, such as PHQ-2, PHQ-9, Edinburgh Postnatal	16. Percentage of clients with a cervix aged 21 or older who were screened for cervical cancer in the last three years. (*HRSA HAB measure*) 17. Percentage of clients aged 12 years and older screened for

Depression Score, or the Geriatric Depression Score ○ Clients with a positive clinical depression screen should have a follow-up plan documented on the date of the assessment • Psychosocial assessment, including domestic violence screening and a housing status assessment to determine if the client is experiencing housing instability or homelessness • Substance use screening • Tobacco use screening • Oral health exam and assessment • Tuberculosis (TB) screening at time of diagnosis and when clinically indicated ○ Chest x-ray should be performed for any client with a newly positive tuberculin skin test or IGRA, or with any clinical concern for tuberculosis • Cervical cancer screen (following the most current clinical recommendations) for clients who have a cervix: ○ Clients Aged 21-29 Years: ▪ Clients aged 21-29 should have a Pap test at the time of initial HIV diagnosis. Pap should be done at baseline and every 12 months. If the results of 3 consecutive Pap tests are normal, follow-up Pap tests can be performed every 3 years. ○ Clients Aged 30 Years or Older: ▪ Pap test *or* Pap test with human papillomavirus (HPV) co-testing should be done at baseline and every 12 months. If results of 3 consecutive Pap tests are normal, follow-up Pap tests can be performed every 3 years. **Anal Dysplasia and Cancer Screening:** There are currently no national guidelines regarding screening for anal cancer and dysplasia. The HHS Clinical Practice Guidelines do not endorse routine anal cytology testing (anal Pap) but note that some specialists do recommend anal cytology for people living with HIV. Annual digital anal rectal examination (DARE) and screening for symptoms of anal dysplasia (anorectal pain, bleeding, masses, or nodules) may also be useful in the early	clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool. (*DSHS-revised HRSA HAB measure*) 18. Percentage of clients 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*) 19. Percentage of clients who were screened for domestic violence at least once during the measurement year. 20. Percentage of clients who received a housing status assessment to determine if they are experiencing housing instability or homelessness, at least once during the measurement year. 21. Percentage of clients who have been screened for substance use (alcohol and drugs) in the measurement year. (*HRSA HAB measure*) 22. Percentage of clients aged 18 years and older who were screened for tobacco use one or more times within 24 months. (*DSHS-revised HRSA HAB*

detection of anal cancers. HHS and the Infectious Disease Society of America both recommend against offering anal cytology if resources are not available for appropriate referral and follow-up of abnormal results, including high-resolution anoscopy (HRA). For clinicians who opt to conduct screenings for anal dysplasia and cancer, the New York State Department of Health offers detailed guidelines (see source list). **Sources:** Preventative care: United States Preventive Services Taskforce (uspreventiveservicestaskforce.org) Tuberculosis screening: Mycobacterium tuberculosis Infection and Disease | NIH (hiv.gov) Depression screening: Depression: Screening and Diagnosis (aafp.org) Cervical cancer screening: Human Papillomavirus Disease | NIH (hiv.gov) Domestic violence screening: Recommendation: Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org) Psychosocial Assessment Questions: page 65, Guide for HIV/AIDS Clinical Care - 2014 Edition Anal dysplasia and cancer screening: Human Papillomavirus Disease | NIH (hiv.gov) Primary Care Guidance for Persons With Human Immunodeficiency Virus (idsociety.org) Screening for Anal Dysplasia and Cancer in Adults With HIV - AIDS Institute Clinical Guidelines (hivguidelines.org)	*measure*) 23. Percentage of clients aged 3 months and older for whom there was documentation that a tuberculosis (TB) screening test was performed (and results interpreted for TB skin tests) at least once since the diagnosis of HIV. (*HRSA HAB measure*)
Immunizations: Providers should give both adult and childhood immunizations according to the most current HHS and CDC recommendations. The CDC maintains specific immunization schedules for both adults and children with HIV, which include modifications based on CD4 count. The HHS HIV/AIDS Clinical Guidelines also contain vaccination guidelines for all ages. Vaccinations should include the following: • Tetanus, diphtheria, and pertussis (Tdap) or tetanus and diphtheria (Td) per	24. Percentage of clients with tetanus, diphtheria, and pertussis (Tdap) or tetanus and diphtheria (Td) vaccination and with a booster every 10 years, or documentation of refusal.

immunizations guidelines.
• Measles, mumps, and rubella (MMR) per immunization guidelines. *Adults and adolescents with a CD4 cell count <200 cells per uL should not receive MMR.*
• Influenza (inactivated vaccine) annually during flu season (October 1st - March 31st). *Live Attenuated Influenza Vaccine (LAIV) is contraindicated for all people living with HIV.*
• Pneumococcal vaccines for all clients, which may include both a pneumococcal conjugate vaccine (PCV13, PCV15, or PCV20) and pneumococcal polysaccharide vaccine (PPSV23). These should be administered according to the most recent guidance from the CDC, which varies according to client age and vaccination history.
• Completion of hepatitis A (HAV) vaccines series, unless otherwise documented as immune.
• Completion of hepatitis B (HBV) vaccines series, unless otherwise documented as immune.
  ○ Vaccinated clients should be tested for hepatitis B surface antibody (HBsAb) response 1–2 months after completing the series or at the next scheduled clinic visit
  ○ Vaccine non-responders may benefit from revaccination
• Meningococcal ACWY (MenACWY) vaccine series for all clients aged 2 months or older. Adults should revaccinate after 5 years.
• Recombinant zoster vaccine (RZV), two doses for all clients aged ≥ 18.
• Primary varicella (chickenpox) vaccine (VAR) series for clients with no prior evidence of varicella immunity (vaccination, prior clinician diagnosis, or laboratory evidence of immunity) and CD4 count ≥ 200. *VAR is contraindicated in clients with CD4 count < 200.*
• Human papillomavirus (HPV) vaccine series for all clients, regardless of gender, between the ages of 11 and 26 (can be initiated as early as 9). For clients ages 27-45 not adequately vaccinated earlier, shared decision making can be used regarding HPV vaccination.
 	
COVID-19 Immunization*:* Providers should offer all clients ages 6 months or older a COVID-19 vaccine primary dose series and boosters. The number of doses may
	25. Percentage of clients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza vaccine (can be client self-report), or documentation of refusal. (*DSHS-revised HRSA HAB measure*)
	26. Percentage of clients aged 2 months or older who ever received a pneumococcal vaccine, or documentation of refusal. *(DSHS-revised HRSA HAB measure)*
	27. Percentage of clients who completed the vaccination series for hepatitis A, unless otherwise documented as immune, or documentation of refusal.
	28. Percentage of clients who completed the vaccination series for hepatitis B, unless otherwise documented as immune, or documentation of refusal. *(DSHS-revised HRSA HAB measure)*
	29. Percentage of clients between the ages of 11 and 26 who have completed the human papillomavirus (HPV) vaccine series, or documentation of refusal.
	30. Percentage of clients aged 6

vary according to the most current guidelines, the vaccine being given, and the client age and immunocompromised status. The Janssen COVID-19 vaccine should only be used in limited situations where a client would otherwise not receive a vaccine; the Pfizer-BioNTech, Moderna, and Novavax vaccines are preferred. COVID-19 vaccine recommendations are evolving and providers should reference the most recent clinical guidance: Clinical Guidance for COVID-19 Vaccination | CDC. **Mpox Immunization:** Providers should base decisions regarding mpox vaccination on the most recent CDC guidance. The JYNNEOS vaccine is considered safe to administer to clients with HIV. *The ACAM2000 vaccine is contraindicated in all people living with HIV.* **Sources:** COVID-19 vaccination: Clinical Care Considerations for COVID-19 Vaccination | CDC Adult immunizations: Immunizations for Preventable Diseases in Adults and Adolescents Living with HIV | NIH Vaccines Indicated for Adults Based on Medical Indications | CDC Pediatric immunizations: Preventing Vaccine-Preventable Diseases in Children and Adolescents with HIV Infection | NIH Vaccines Indicated for Persons Aged 0 through 18 years Based on Medical Indications | CDC Zoster vaccination: Clinical Considerations for Use of Recombinant Zoster Vaccine (RZV, Shingrix) in Immunocompromised Adults Aged ≥19 Years | CDC Mpox vaccination: Considerations for Mpox Vaccination | Mpox | Poxvirus | CDC	months or older who ever received a COVID-19 vaccine (can be client self-report), or documentation of refusal. (Pilot Measure)
Antiretroviral Therapy: Primary medical care for HIV includes prompt initiation of ART. Providers should offer and prescribe ART for all clients in accordance with current HHS Guidelines for the Use of Antiretroviral Agents. Providers should initiate prophylaxis for specific opportunistic infections (OIs) in clients who meet CD4 thresholds or have other risk factors for OI. Both prophylaxis and treatment for opportunistic infections should be provided in accordance with HHS Guidelines for the Prevention and Treatment of Opportunistic Infection.	31. Percentage of clients, regardless of age, who were prescribed antiretroviral therapy (ART) for the treatment of HIV during the measurement year. *(HRSA HAB measure)*

Sources: ART: Guidelines for the Use of Antiretroviral Agents for Adults and Adolescents with HIV | NIH (hiv.gov) OI prophylaxis: Guidelines for the Prevention and Treatment of Opportunistic Infection in Adults and Adolescents | NIH (hiv.gov)	
Health Education and Risk Reduction: Providers or other members of the interdisciplinary team should provide routine risk-reduction counseling, sexual health promotion, and behavioral health counseling for clients living with HIV. Since clients' behaviors and social situations may change over time, health education should be tailored not just to the individual client but also to the point of time in the client's life. The following education and counseling should be conducted initially and as needed: • Providers or members of the interdisciplinary team should inform clients that maintaining a plasma HIV RNA (viral load) of <200 copies per mL with antiretroviral therapy prevents sexual transmission of HIV to their partners. Clients may recognize this concept as Undetectable = Untransmittable or U=U. • Providers or members of the interdisciplinary team should discuss safer sexual practices that decrease risk of transmitting HIV, such as treatment as prevention, condom use, preexposure prophylaxis (PrEP) for partners, and reducing or abstaining from sexual activity. • Providers or members of the interdisciplinary team should counsel clients regarding ways HIV is transmitted, including anal and vaginal sex, shared injection equipment, and during pregnancy, birth, and breastfeeding. • Medical providers should discuss family planning with clients and provide contraception counseling, including information about hormonal contraception, as applicable. • Medical providers, health educators, or licensed chemical dependency counselors should counsel clients on tobacco cessation annually for those clients who endorse tobacco use. • When current alcohol or other substance use is identified, medical providers should discuss the possible effects of such use on the client's general health	32. Percentage of clients who received HIV risk counseling in the measurement year. (*HRSA HAB measure*) 33. Percentage of clients aged 18 years and older who received cessation counseling intervention if identified as a tobacco user. (*DSHS-revised HRSA HAB measure*) 34. Percentage of clients with documented counseling about the risk of acquiring syphilis and other STIs from unprotected sexual contact, including all applicable routes of transmission (anal, oral, or vaginal sex), within the measurement year. 35. Percentage of clients with documented counseling about family planning methods appropriate to the client's status, including preconception counseling as applicable, within the measurement year.

and HIV medications, as well as options for treatment if indicated. • Providers or members of the interdisciplinary team should routinely discuss with clients the importance of disclosure to partners. Clients should be educated about the options for voluntary partner notification. • Providers or members of the interdisciplinary team should counsel clients about the risk of acquiring syphilis and other STIs from sex, including all applicable sites of transmission (anus, cervix, vagina, urethra, and oropharynx) and risk reduction strategies. • Providers or members of the interdisciplinary team should educate clients on nutrition and physical activity, as medically indicated. **Sources:** Primary Care Guidance for Persons With Human Immunodeficiency Virus: 2020 Update (idsociety.org) Treatment as Prevention (TasP): Antiretroviral Therapy to Prevent Sexual Transmission of HIV (Treatment as Prevention) | NIH Smoking Cessation: page 189-196, Guide for HIV/AIDS Clinical Care - 2014 Edition Nutrition: page 197-202, Guide for HIV/AIDS Clinical Care - 2014 Edition	
Treatment Adherence and Retention in Care: Providers and members of the interdisciplinary team should assess and promote adherence and retention in care for all clients. Clients who are prescribed ART should receive adherence assessment and counseling at every HIV-related clinical encounter, twice a year at minimum. When an adherence issue is identified by another member of the healthcare team, the prescribing provider must be made aware of the concern and should ensure adherence counseling and follow-up has been documented. Adherence interventions should be tailored to the individual client, and may include: • Prescribing regimens with high barriers to genetic resistance. • Changing ART to simplify dosing and reduce side effects. • Addressing underlying cost and medication access concerns. • Multidisciplinary approaches, including social work, case management,	36. Percentage of clients, regardless of age, with an HIV viral load less than 200 copies per mL at last HIV viral load test during the measurement year. *(HRSA HAB measure)* 37. Percentage of clients with an unsuppressed viral load on ART who were assessed for treatment adherence two or more times within the measurement year. 38. Percentage of clients, regardless of age, who did not have a medical visit in the last

counseling, and mental health care. To increase retention in HIV care, providers or other members of the interdisciplinary team should: • Document number of missed client appointments and efforts to bring the client into care. • Contact clients who have missed appointments, using at least three different forms of contact (phone, mail, emergency contact, referral to DIS) prior to determining they are lost to follow-up. • Address any specific barriers to accessing services. **Sources:** Adherence to the Continuum of Care | NIH (hiv.gov) Page 273, Guide for HIV/AIDS Clinical Care, 2014 Edition Evidence-based adherence and retention-in-care interventions: Compendium | Intervention Research | Research | HIV | CDC	6 months of the measurement year. (*HRSA HAB measure*) 39. Percentage of clients, regardless of age, 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. (*HRSA HAB measure*) 40. Percentage of client medical records with documentation of any specific barriers and efforts made to address missed appointments.
Referrals: Providers should refer to specialty care or other systems as appropriate in accordance with current HHS guidelines. Providers or clinic staff should follow up on each referral to assess attendance and outcomes. At a minimum, clients should receive referrals to the following specialized services, as needed or medically indicated to augment their medical care: • AIDS Drug Assistance Program (ADAP) • Medication Assistance Programs • Medical care coordination • Medical specialties • Mental health and substance use services • Adherence counseling • Partner counseling and referral • Annual oral hygiene and intraoral examinations by a dentist • Medical nutrition therapy (MNT)	41. Percentage of clients with a cervix aged 21 or older who received a referral at least every 3 years for cervical cancer screening if this service is not available on site. 42. Percentage of clients with documented referral to dentist for oral healthcare or documentation that client is already seeing a dentist (can be client self-report) within the measurement year. 43. Percentage of clients aged 18 or younger with referral if abuse is suspected; proper authorities contacted and

• Preventative care, including: • Cervical cancer screening • Family planning • Colorectal cancer screening • Breast cancer screening • Case management services or disease intervention specialist (DIS) • Vision care • Audiology Providers or staff are expected to follow-up on each referral to assess attendance and outcomes. When OAHS is used for specialty care, the specialty care service standards and measures should be followed. **Sources:** Page 10-11, 73, Guide to HIV/AIDS Clinical Care - 2014 Edition (hrsa.gov) Primary Care Guidance for Persons With Human Immunodeficiency Virus: 2020 Update (idsociety.org) United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)	documented in client's file.
Documentation in Client Medical Chart: Providers or other members of the interdisciplinary team will develop or update the plan of care at each visit. Documentation should include the following: ▪ Current and complete problem list ▪ Current and complete medication list ▪ Documentation of any refused treatment, such as a vaccination ▪ Signature of the provider developing the plan; an electronic signature is allowable. *Source*: Section 2, Page 77, Guide for HIV/AIDS Clinical Care - 2014 Edition (hrsa.gov)	44. Percentage of client medical records with signed clinician entries. 45. Percentage of problem lists present and updated in the client medical records. 46. Percentage of medication lists present and updated in the client medical records.
Perinatally Exposed Infants: Infants exposed to HIV during pregnancy, labor and	47. Percentage of infants born to

delivery, or breastfeeding should receive clinical care consistent with the most current NIH guidelines. **Antiretroviral Therapy:** All newborns perinatally exposed to HIV should receive postpartum ART to reduce the risk of perinatal transmission of HIV. Newborn ART regimens—at gestational age-appropriate doses—should be initiated as close to the time of birth as possible, preferably within 6 hours of delivery. Selection of ART and duration of therapy should be guided by transmission risk, and whether it is intended as HIV prophylaxis, presumptive HIV therapy, or HIV therapy. Detailed recommendations are available in the HHS Perinatal HIV Clinical Guidelines. 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. **Diagnostic Testing to Exclude HIV Diagnosis in Exposed Infants:** Virologic diagnostic testing is recommended for all infants with perinatal HIV exposure at 14-21 days, 1-2 months, and 4-6 months. For infants at high risk for perinatal HIV transmission, testing should also be conducted at birth and 2-6 weeks after antiretroviral drugs have been discontinued. Assays that directly detect HIV RNA or DNA must be used to diagnose HIV in infants and children aged <18 months. **For comprehensive clinical guidance:** Perinatal HIV Clinical Guidelines | NIH (hiv.gov)	people living with HIV who received recommended virologic diagnostic testing for exclusion of HIV diagnosis in the measurement year. (*HRSA HAB measure*)

Specialty Care Service Standards and Measures:

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. These standards are applicable only when the Outpatient Ambulatory Health Services category funds specialty care referrals, including but not limited to dermatology, neurology, obstetrics and gynecology, oncology, ophthalmology, and radiology.

Standard	Measure
Referrals to Specialty Care: Clients receiving specialty care services should have documentation of a referral to those services made by a licensed medical provider (with the exception of optometry services, for which a client can self-refer). Referrals should include documentation of how specialty care is related to HIV diagnosis. If a client self-refers to optometry the client chart should contain documentation that vision services will support the goals of HIV treatment. Documentation from each specialty visit should be present in the client record and should include an updated plan of care and the signature of the provider (an electronic signature is allowable). OAHS funds may only be used for contact lenses and contact lens-related appointments when there is no other option to correct or ameliorate a visual defect. See details under 'Limitations.' **Sources:** Policy Clarification Notice (PCN) 16-02 Make Referrals Easy | Agency for Healthcare Research and Quality (ahrq.gov) High Value Care Coordination (HVCC) Toolkit | ACP (acponline.org)	48. Percentage of clients receiving specialty care services (other than optometry) who have a referral for those services and documentation of how specialty care is related to HIV diagnosis. (Pilot Measure) 49. Percentage of clients receiving specialty care services with signed clinician documentation for each visit in the measurement year. (Pilot Measure)

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