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

DRAFT

Health Resources and Services 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) and 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.

DRAFT

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 PCN 07-02, diagnostic and laboratory testing provided under OAHS must meet the following conditions:

- It is consistent with medical and laboratory standards as established by scientific evidence and supported by professional panels, associations, or organizations;
- Either the U.S. Food and Drug Administration (FDA) approved it when required under the FDA Medical Devices Act; or a Clinical Laboratory Improvement Amendments of 1988 (CLIA)-certified laboratory or State-exempt laboratory performs it;
- A registered, certified, or licensed medical provider ordered it; and
- It is necessary and appropriate based on established clinical practice standards and clinical judgment.

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

- Medical providers may consider contact lenses for clients of any age if there is no other option available to correct or ameliorate a visual defect.
- DSHS limits contact lenses to once every 24 months. DSHS allows additional services within the 24-month period 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-##.

DRAFT

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. DSHS bases these standards on national guidelines, including the 2024 Health and Human Services (HHS) HIV clinical guidelines and the Infectious Disease Society of America Clinical Practice Guidance. The standard also links to additional sources where applicable. Clinical knowledge is continuously evolving, and providers will deliver care in accordance with the most recent available guidelines. The Primary Care Service Standards and Measures are applicable when agencies use OAHS 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 relevant medical, psychosocial, and family history. Providers can complete this during the initial visit or divide it over the course of two or three early visits. Providers will 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 HIV-related illness
• Past medical and surgical history, including:
  ▸ Chronic conditions and comorbidities
  ▸ Gynecological and obstetric history, as applicable
  ▸ Immunizations
  ▸ Current medications
  ▸ Allergies and medication hypersensitivities
• Psychosocial history, including:
	1. Percentage of clients with a documented comprehensive HIV-related history, inclusive of all the components listed in the OAHS Standard.

DRAFT

- Mental health history - Sexual health history - Social history - Current and past use of substances, including tobacco use - Current and past experiences of interpersonal violence, including physical and sexual abuse and domestic violence - Housing status - Travel history, if applicable • Family history - Diabetes - Early heart disease - Hypertension - Hyperlipidemia - Cancer **Sources:** Baseline Evaluation: Adults and Adolescents with HIV | NIH 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 will perform a baseline and annual comprehensive physical examination, with attention to the areas potentially affected by HIV. **Sources:** 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.

DRAFT

Laboratory Tests: Providers will follow the most recent HHS guidelines, which contain detailed recommendations on laboratory tests for an initial assessment and treatment monitoring, including the appropriate testing intervals. A licensed provider must order all tests. Initial laboratory testing will include: • 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 experts recommend resistance testing). *Providers will not delay ART initiation pending the results of resistance testing.* • Complete blood count (CBC) with differential. • Complete metabolic panel (CMP) or a basic metabolic panel (BMP) and liver function tests, including alanine transaminase (ALT), aspartate transaminase (AST), and total bilirubin. • Lipid profile (random or fasting). • Urinalysis (UA). • Hepatitis A antibody, hepatitis B serology (surface antigen, core antibody, and surface antibody), and hepatitis C antibody screens at the initial intake, and when otherwise clinically indicated. • Syphilis screening. • Gonorrhea (GC) and chlamydia (CT) testing at all applicable sites. Providers will order the following tests as part of initial labs when appropriate: • Pregnancy test for clients of childbearing potential. • Human leukocyte antigen (HLA) B*5701 when the provider is considering an abacavir-containing regimen. • Coreceptor tropism testing when the provider is considering a CCR5 antagonist. • Glucose-6-phosphate dehydrogenase (G6PD) for clients in certain racial or	3. Percentage of clients with documentation for all lab tests performed, to include: a. The laboratory performing the test. b. The credentials of the individual ordering the test. 4. Percentage of clients who had an HIV drug resistance test performed before or at the time of initiation of antiretroviral therapy, if therapy started during the measurement year. 5. Percentage of clients with a documented CD4 count (absolute) within the measurement year. 6. Percentage of clients with a documented HIV viral load within the measurement year. 7. Percentage of clients with a documented complete blood count (CBC) with differential and platelets within the measurement year. 8. Percentage of clients with either a documented comprehensive metabolic panel (CMP) or a basic metabolic panel (BMP) and liver function testing, during the measurement year.

DRAFT

ethnic groups when the provider is considering oxidant drugs. • Trichomonas for clients practicing receptive vaginal sex. • Varicella and measles immunity testing in clients without documented immunity. Routine laboratory monitoring will include: • CD4 count annually, and more frequently as indicated. • HIV viral load every six months, and more frequently as indicated. • CMP or BMP and liver function tests (including ALT, AST, and total bilirubin) annually, and more frequently as indicated. • CBC with differential annually, and more frequently as indicated. • Lipid profile in accordance with cardiovascular risk. • Syphilis screening annually and more frequently as indicated. • Gonorrhea (GC) and chlamydia (CT) testing at all applicable sites annually and more frequently as indicated. • Trichomonas testing for clients practicing receptive vaginal sex annually and more frequently as indicated. **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)	9. Percentage of clients who were prescribed ART and who had a random or fasting lipid panel at least once since the diagnosis of HIV. 10. Percentage of clients at risk for sexually transmitted infections (STIs) who had gonorrhea testing at all applicable sites within the measurement year. 11. Percentage of clients at risk for STIs who had chlamydia testing at all applicable sites within the measurement year. 12. Percentage of adult clients who had a test for syphilis performed within the measurement year. 13. 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. 14. 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 a documented infection or immunity.

DRAFT

	15. Percentage of clients for whom a hepatitis C screening was performed at least once since the diagnosis of HIV.

Screenings and Assessments: People living with HIV are at increased risk for developing cardiovascular disease, certain cancers, metabolic disorders, loss of bone mineral density, and neurocognitive disorders. Providers will conduct routine preventative health services, screening for opportunistic infections as applicable, and an assessment of psychosocial needs as appropriate. For detailed information on screening modalities and timelines, refer to the United States Preventative Taskforce (see source list).
 	
Screening will include at a minimum:
• Mental health assessment at least annually with an age-appropriate, standardized screening for clinical depression. Validated tools include the Patient Health Questionnaire (PHQ)-2, PHQ-9, Edinburgh Postnatal Depression Score, and the Geriatric Depression Score.
    ‣ Clients with a positive clinical depression screen have a follow-up plan documented by the provider on the date of the assessment.
• Housing status assessment to determine if the client is experiencing housing instability or homelessness, as applicable.
• Domestic violence screening, as applicable.
• Substance use screening.
• Oral health exam and assessment by a dentist.
• Tuberculosis (TB) screening at the time of diagnosis and when clinically indicated.
    ‣ Providers will order a chest x-ray for a client with a newly positive tuberculin skin test or interferon-gamma release assay (IGRA), or with a clinical concern for tuberculosis.
• Cervical cancer screen for clients who have a cervix. Providers who do not conduct screenings on site will refer clients to an outside provider for screening:
	16. Percentage of clients with a cervix, ages 21 or older, who were screened for cervical cancer in the last three years *or* who received a referral for cervical cancer screening, if the screening was not available onsite.
	17. Percentage of clients aged 12 years and older screened for clinical depression within the measurement year using an age- appropriate standardized depression screening tool.
	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.
	19. Percentage of clients who have been screened for substance use (alcohol and drugs) in the measurement year.
	20. Percentage of clients aged 3 months and older for whom there was documentation that a tuberculosis (TB) screening test was performed (and

DRAFT

‣ Clients Ages 21-29 Years: ▪ Clients ages 21-29 will have a Pap test at the time of initial HIV diagnosis. Providers will perform a Pap at baseline and every 12 months. If the results of three consecutive Pap tests are normal, providers can perform follow-up Pap tests every 3 years. ‣ Clients Aged 30 Years or Older: ▪ Providers will perform a Pap test *or* Pap test with human papillomavirus (HPV) co- testing at baseline and every 12 months. If results of three consecutive Pap tests are normal, providers can perform follow-up Pap tests every 3 years. • Anal cancer screening for adult clients, following the most recent HHS Guidelines. • Atherosclerotic cardiovascular disease (ASCVD) risk estimation using a validated calculator for clients aged 40-75. ‣ For clients with a 10-year ASCVD risk of 5 percent to <20 percent, the HHS Clinical Guidelines recommend initiating at least a moderate- HHS Clinical Guidelines recommend initiating at least a moderate-intensity statin therapy. **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) Anal dysplasia and cancer screening: Human Papillomavirus Disease | NIH (hiv.gov) Statin therapy: Statin Therapy in People With HIV | NIH	results interpreted for TB skin tests) at least once since the diagnosis of HIV.
Immunizations: Providers will give both adult and pediatric immunizations according to the most current HHS and CDC recommendations. The CDC maintains specific	21. Percentage of clients with documentation of

DRAFT

immunization schedules for both adults and children with HIV, which include modifications based on CD4 count:

- Adult Immunization Schedule, By Medical Indications | CDC
- Birth-18 Years Immunization Schedule, By Medical Condition | CDC

The HHS HIV/AIDS Clinical Guidelines also provide vaccination guidance for adults, adolescents, and children:

- Immunizations for Preventable Diseases in Adults and Adolescents with HIV | NIH
- Preventing Vaccine-Preventable Diseases in Children and Adolescents with HIV Infection | NIH

Providers will ensure clients receive all vaccinations with specific recommendations based on HIV status. These include the Covid-19 vaccine series, the hepatitis A vaccine series, the hepatitis B vaccine series, the recombinant zoster vaccine series (RZV), the meningococcus serogroup A, C, W, Y (MenACWY) vaccine series, and at least one dose of a pneumococcal vaccine.

When clients self-report a history of vaccination but medical records are not available, providers should use clinical judgement to determine whether to repeat vaccination, order serologic testing to determine immunity status, or accept the client's self-report. The Advisory Committee on Immunization Practices (ACIP) recommends that in most circumstances, providers order vaccine doses for adults with unknown vaccine status (except for influenza vaccines and pneumococcal polysaccharide vaccines).

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

immunizations with special recommendations related to HIV status (including client self-report), or documentation of refusals: (Pilot measure)

a. At least one dose of a Covid-19 vaccine for clients 6 months or older
b. Hepatitis A vaccine series for clients without evidence of immunity
c. Hepatitis B vaccine series for clients without evidence of immunity
d. Recombinant zoster vaccine series for clients 18 years or older
e. Meningococcus serogroup A, C, W, Y vaccine series for clients 2 years or older
f. At least one dose of a pneumococcal vaccine for clients 2 months or older

DRAFT

[| 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	
Antiretroviral Therapy: Primary medical care for HIV includes prompt initiation of ART. Providers will offer and prescribe ART for all clients in accordance with current HHS Guidelines for the Use of Antiretroviral Agents. Providers will initiate prophylaxis for specific opportunistic infections (OIs) in clients who meet CD4 thresholds or have other risk factors for OI. Providers will provide both prophylaxis and treatment for opportunistic infections in accordance with the HHS Guidelines for the Prevention and Treatment of Opportunistic Infection. **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)	22. Percentage of clients, regardless of age, who were prescribed antiretroviral therapy (ART) for the treatment of HIV during the measurement year.
Health Education and Risk Reduction: Providers or other members of the interdisciplinary team will 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, staff will tailor health education to the individual client. Providers or other members of the interdisciplinary team will conduct the following education and counseling: • Providers or members of the interdisciplinary team will 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 will discuss safer sexual practices that decrease risk of transmitting HIV, such as treatment as prevention, condom use, preexposure prophylaxis (PrEP) for partners, and	23. Percentage of clients who received HIV risk counseling in the measurement year. 24. 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. 25. Percentage of clients of

DRAFT

reducing or abstaining from sexual activity. • Providers or members of the interdisciplinary team will counsel clients regarding behaviors that transmit HIV, including anal and vaginal sex, shared injection equipment, and during pregnancy, birth, and breastfeeding. • Medical providers will discuss family planning with clients of childbearing potential. Clients of childbearing potential includes all premenopausal clients who are capable of becoming pregnant, regardless of contraceptive use or sexual practices. Family planning counseling will be consistent with the HHS Clinical Guidelines and include, as applicable, information about contraceptive methods, safer sex, interventions to prevent perinatal HIV transmission, and potential interactions of ART regimens with pregnancy and contraceptives. • When providers identify current alcohol or other substance use, medical providers will discuss the possible effects of such use on the client's general health and HIV medications, as well as options for treatment if indicated. • Providers or members of the interdisciplinary team will routinely discuss with clients the importance of disclosure to partners and educate clients about the options for voluntary partner notification. • Providers or members of the interdisciplinary team will 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 will 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	childbearing potential with documented counseling about family planning methods appropriate to the client's status, including preconception counseling as applicable, within the measurement year.
Treatment Adherence and Retention in Care: Providers and members of the interdisciplinary team will assess and promote adherence and retention in care for clients. Clients who are prescribed ART will receive adherence assessment and counseling at every HIV-related clinical encounter, twice a year at minimum. When	26. Percentage of clients with an unsuppressed viral load on antiretroviral therapy who staff assessed for treatment

another member of the healthcare team identifies an adherence issue, they must notify the prescribing provider of the concern and document counseling and follow-up. Staff will tailor adherence interventions 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, counseling, and mental health care. To increase retention in HIV care, providers or other members of the interdisciplinary team will: • 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 specific barriers to accessing services. **Sources:** Adherence to the Continuum of Care | NIH (hiv.gov) Evidence-based adherence and retention-in-care interventions: Compendium | Intervention Research | Research | HIV | CDC	adherence two or more times within the measurement year. 27. Percentage of client medical records with documentation of specific barriers and efforts made to address missed appointments.
Referrals: Providers will refer to specialty care or other systems as appropriate in accordance with current HHS guidelines. Providers or clinic staff will follow up on each referral to assess attendance and outcomes. At a minimum, clients will receive referrals to the following specialized services, as needed or medically indicated to augment their medical care: • AIDS Drug Assistance Program (ADAP) • Pharmaceutical patient assistance programs (PAPs) • Care coordination services	28. 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.

DRAFT

- Medical Case Management (MCM)
- Non-Medical Case Management (NMCM)
- Referral for Healthcare and Support Services (RHCS)
• Medical specialties
• Mental health and substance use services
• Adherence counseling
• Partner counseling and referral, including PrEP services
• Annual oral hygiene and intraoral examinations by a dentist
• Medical nutrition therapy (MNT)
• Preventative care, including:
  - Cervical cancer screening
  - Family planning
  - Colorectal cancer screening
  - Breast cancer screening
  - Bone densitometry (DXA) screening
• Disease intervention specialist (DIS)
• Vision care
• Audiology
 	
Providers or staff will follow up on each referral to assess attendance and outcomes. When agencies use OAHS for specialty care, DSHS requires agencies to follow the specialty care service standards and measures.
 	
Sources:
Primary Care Guidance for Persons With Human Immunodeficiency Virus: 2020 Update (idsociety.org)
United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)	

DRAFT

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 will include the following: ▪ Current and complete problem list ▪ Current and complete medication list ▪ Documentation of refused treatment, such as a vaccination ▪ Signature of the provider developing the plan; an electronic signature is allowable.	29. Percentage of client medical records with signed clinician entries.

DRAFT

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 will have documentation of a referral to those services made by a licensed medical provider (except for optometry services, for which a client can self-refer). Referrals will include documentation of how specialty care is related to HIV diagnosis. Documentation must show that the specialty care is related either to the client's HIV infection or to conditions arising from HIV treatment, such as adverse effects of medication. If a client self-refers to optometry the client chart will contain documentation that vision services support the goals of HIV treatment. Documentation from each specialty visit will be present in the client record and include an updated plan of care and the signature of the provider (an electronic signature is allowable). Agencies may only use OAHS funds may 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)	30. 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. 31. Percentage of clients receiving specialty care services with signed clinician documentation for each visit in the measurement year.

DRAFT

References:

Agency for Healthcare Research and Quality. (2024, April). *Health Literacy Universal Precautions Toolkit, 3rd Edition*. AHRQ.gov. ahrq.gov/health-literacy/improve/precautions/tool21.html

American College of Physicians. (2010). *High Value Care Coordination (HVCC) Toolkit*. acponline.org. acponline.org/clinical-information/high-value-care/resources-for-clinicians/high-value-care-coordination-hvcc-toolkit

Centers for Disease Control and Prevention. (2024, March 22). *STI Screening Recommendations*. CDC.gov; Centers for Disease Control and Prevention. cdc.gov/std/treatment-guidelines/screening-recommendations.htm

Centers for Disease Control and Prevention, National Center for Emerging and Zoonotic Infectious Diseases. (2024, April 22). *Interim Clinical Considerations for Use of JYNNEOS Vaccine for Mpox Prevention in the United States.* CDC.gov; Centers for Disease Control and Prevention. cdc.gov/poxvirus/monkeypox/health-departments/vaccine-considerations.html

Division of HIV Prevention, National Center for HIV, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention. (2024, May 16). *Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention*. CDC.gov; Centers for Disease Control. cdc.gov/hiv/research/interventionresearch/compendium/index.html

Guidelines Working Groups of the NIH Office of AIDS Research Advisory Council. (2022, February 22). *What's New: COVID-19 and HIV Guidance*. Clinical Info (HIV.gov); Department of Health and Human Services. clinicalinfo.hiv.gov/en/guidelines/guidance-covid-19-and-people-hiv/whats-new-covid-19-and-hiv-guidance

MacGowan, J. P., Fine, S. M., Vail, R., Merrick, S. T., Radix, A., Hoffmann, C. J., & Gonzalez, C. J. (2024, January 17). *Screening for Anal Dysplasia and Cancer in Adults With HIV*. AIDS Institute Clinical Guidelines; Clinical Guidelines Program. hivguidelines.org/hiv-care/anal-cancer/

Maurer, D. M., Raymond, T. J., & Davis, B. N. (2018). Depression: Screening and Diagnosis. *American Family Physician*, *98*(8), 508–515. aafp.org/pubs/afp/issues/2018/1015/p508.html

DRAFT

National Center for Immunization and Respiratory Diseases. (2023, November 16). *Adult Immunization Schedule by Medical Condition and Other Indication* CDC.gov; Centers for Disease Control and Prevention. cdc.gov/vaccines/schedules/hcp/imz/adult-conditions.html

National Center for Immunization and Respiratory Disease. (2022, January 20). *Clinical Considerations for Use of Recombinant Zoster Vaccine (RZV, Shingrix) in Immunocompromised Adults Aged ≥19 Years*. CDC.gov; Centers for Disease Control and Prevention. cdc.gov/shingles/vaccination/immunocompromised-adults.html

National Center for Immunization and Respiratory Disease. (2023, November 2). *Clinical Care Considerations for COVID-19 Vaccination*. CDC.gov; Centers for Disease Control and Prevention. cdc.gov/vaccines/covid-19/clinical-considerations/

National Center for Immunization and Respiratory Diseases. (2023, November 16). *Child and Adolescent Immunization Schedule by Medical Indication*. CDC.gov; Centers for Disease Control and Prevention. cdc.gov/vaccines/schedules/hcp/imz/child-indications.html

Panel on Antiretroviral Guidelines for Adults and Adolescents. (2024, February 27). *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV*. Clinical Info (HIV.gov); Department of Health and Human Services. clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/whats-new-guidelines

Panel on Antiretroviral Therapy and Medical Management of Children Living with HIV. (2024, January 31). *Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection*. Clinical Info (HIV.gov); Department of Health and Human Services. clinicalinfo.hiv.gov/en/guidelines/pediatric-arv

Panel on Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. (2024, May 2). *Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV*. Clinical Info (HIV.gov); Department of Health and Human Services. clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-opportunistic-infection

Panel on Opportunistic Infections in HIV-Exposed and HIV-Infected Children. (2023, September 14). *Guidelines for the Prevention and Treatment of Opportunistic Infections in Children with and Exposed to HIV*. Clinical Info (HIV.gov); Department of Health and Human Services. clinicalinfo.hiv.gov/en/guidelines/pediatric-opportunistic-infection

DRAFT

Panel on Treatment of HIV During Pregnancy and Prevention of Perinatal Transmission. (2024, January 31). *Recommendations for the Use of Antiretroviral Drugs During Pregnancy and Interventions to Reduce Perinatal HIV Transmission in the United States*. Clinical Info (HIV.gov); Department of Health and Human Services. clinicalinfo.hiv.gov/en/guidelines/perinatal

Ryan White HIV/AIDS Program. (2007). *Policy Notice 07-02: The Use of Ryan White HIV/AIDS Program Funds for HIV Diagnostics and Laboratory Tests Policy*. Health Resources & Services Administration. ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/hivdiag-test-pn-0702.pdf

Ryan White HIV/AIDS Program. (2018). *Policy Notice 16-02: Eligible Individuals & Allowable Uses of Funds*. Health Resources & Services Administration. ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/service-category-pcn-16-02-final.pdf

Ryan White HIV/AIDS Program. (2024, March). *Performance Measure Portfolio*. Ryanwhite.hrsa.gov; Health Resources & Services Administration. ryanwhite.hrsa.gov/grants/performance-measure-portfolio

Texas Medicaid & Healthcare Partnership. (2023, November). *Texas Medicaid Provider Procedures Manual, Vision and Hearing Services Handbook.* tmhp.com/sites/default/files/file-library/resources/provider-manuals/tmppm/pdf-chapters/2023/2023-11-november/2_20_Vision_and_Hearing_Srvs_0.pdf

Thompson, M. A., Horberg, M. A., Agwu, A. L., Colasanti, J. A., Jain, M. K., Short, W. R., Singh, T., & Aberg, J. A. (2020). Primary Care Guidance for Persons with Human Immunodeficiency Virus: 2020 Update by the HIV Medicine Association of the Infectious Diseases Society of America. *Clinical Infectious Diseases*, *73*(11), e3572–e3605. doi.org/10.1093/cid/ciaa1391

U.S. Department of Health & Human Services. (n.d.). CLAS Standards. Think Cultural Health; Department of Health & Human Services. thinkculturalhealth.hhs.gov/clas/standards

U.S. Preventative Services Task Force. (2024). *Recommendation Topics*. uspreventiveservicestaskforce.org. uspreventiveservicestaskforce.org/uspstf/recommendation-topics

DRAFT

U.S. Preventative Services Taskforce. (2018, October 23) *Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening.* U.S. Preventative Services Taskforce. uspreventiveservicestaskforce.org/uspstf/document/evidence-summary/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening

Walensky, R., Jernigan, D., Bunnell, R., Layden, J., Kent, C., Gottardy, A., Leahy, M., Martinroe, J., Spriggs, S., Yang, T., Doan, Q., King, P., Starr, T., Yang, M., Jones, T., Boulton, M., Brooks, C., Ma, J., Butler, V., & Caine, J. (2021). Sexually Transmitted Infections Treatment Guidelines, 2021. *Morbidity and Mortality Weekly Report Recommendations and Reports*, *70*(4). cdc.gov/std/treatment-guidelines/STI-Guidelines-2021.pdf

DRAFT