Primary Medical Care — Pediatric Services

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1. **Service Definition**

The primary medical care — pediatric service category is defined as the provision of professional, diagnostic and therapeutic services rendered by a physician, physician’s assistant, clinical nurse specialist or nurse practitioner in a pediatric outpatient setting for both HIV-exposed infants and HIV-infected children. These services include:

- Diagnostic testing.
- Early intervention and risk assessment.
- Preventive care and screening.
- Practitioner examination.
- Medical history taking.
- Diagnosis and treatment of common physical and mental conditions.
- Prescribing and managing medication therapy.
- Education and counseling the child and/or parent/caregiver on health and nutritional issues.
- Well-baby care.
- Continuing care and management of chronic conditions.
- Referral to and provision of specialty care.

Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the U.S. Public Health Service’s (PHS) guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. Actual treatment guidelines are updated frequently. Check the PHS web site for current treatment guidelines.

As used herein, the term “client” encompasses the terms “patient” and “service consumer.” The term “provider” refers to clinical program, agency or facility.

1.1. **Key Services**

Key services include:

1.1.1. Diagnostic screening, testing and treatment for HIV-exposed infants.
1.1.2. Diagnostic screening, testing and treatment for HIV-infected children.
1.1.3. Risk assessment.
1.1.4. Preventive care.
1.1.5. Education and counseling for child, parents and caretakers

2. Service Standards of Care

The following are minimum standards for the provision of these services. Agencies and individuals may exceed these standards.

2.1. Baseline Evaluation

An initial medical evaluation should contain a medical and social history, a physical examination and additional documentation, as follows:

2.1.1. One of the two following:
   2.1.1.1. History of HIV-positive status, including the location of the first or latest positive test and documentation of possible risk factor(s) for HIV infection.
   2.1.1.2. History of HIV-exposure, including the factors which may impact infant infection risk (e.g. maternal anti-retroviral treatment, maternal viral load, mode of delivery, maternal hepatitis B and C status)

2.1.2. Age-related developmental history or examination.

2.1.3. History of TB testing, exposure and/or prophylaxis. PPD should be performed on an as-needed basis, depending on risk.

2.1.4. Physical examination including: baseline body weight, height and head circumference (if indicated), temperature and vital signs.

2.1.5. Neurological examination.

2.1.6. Oral examination.

2.1.7. Confirmation of HIV exposure or infection by laboratory means. Infants should be tested by virologic tests (HIV DNA PCR), at age one to two months and at three to six months.

2.1.8. Serologic testing will be based on maternal history (e.g., Hep C) or low CD4 (CMV, Toxoplasmosis)

2.1.9. Evaluation of need for opportunistic infection prophylaxis, based on age and CD4 count or CD4 percentage.
   2.1.9.1. Age 1-5 years, CD4 count <500 or CD4 percentage <15%, initiate PCP prophylaxis.
   2.1.9.2. Age 6-12 years. CD4 count <200 or CD4 percentage <15%, initiate PCP prophylaxis.
   2.1.9.3. Age 0-12 months, CD4 count <750, initiate MAC prophylaxis.
2.1.9.4. Age 1-2 years, CD4 count <500, initiate MAC prophylaxis.
2.1.9.5. Age 2-6 years, CD4 count <75, initiate MAC prophylaxis.
2.1.9.6. Over 6 years, CD4 count <50, initiate MAC prophylaxis.

2.1.10. Education on chicken pox exposure and other reasons to call the doctor.

2.1.11. Status of immunizations, including dates. Update if necessary.

2.1.12. Discussions with child/parent/caregiver of compliance and adherence issues, possible side effects of proposed medications and medical implications, dosing schedules. This applies to children on HAART and needs to be documented when a new antiretroviral treatment is initiated.

2.1.13. Assessment of health and social conditions that may affect compliance with medical appointments (e.g., homelessness, mental illness, substance abuse) or consideration for case management.

2.2. Further or Continued Services

2.2.1. Follow-up visits should record:

2.2.2. Follow-up visits are recommended for most patients every three months; for some patients doing well for long periods of time with long-standing undetectable viral load, the follow up can occur every four months.

2.2.3. History, including medical history since last visit.

2.2.4. Age-related developmental history or examination including body weight, head circumference (if indicated), height, temperature and vital signs.

2.2.5. Oral examination.

2.2.6. Neurological examination.

2.2.7. History of TB, exposure and/or prophylaxis. PPD should be performed on an as-needed basis, depending on risk.

2.2.8. Assessment of compliance problems or consideration for case management.

2.2.9. Repeat of CD4 and HIV viral-load measurements.

2.2.10. Evaluate need for opportunistic infection (OI) prophylaxis, based on age and CD4 count or CD4 percentage (see 2.1.9).

2.2.11. Immunization status; immunizations as indicated.

2.2.12. Discussions with child/parent/caregiver of compliance and adherence issues, possible side effects of proposed medications and medical implications. This applies to children on HAART.

2.2.13. Treatment must be consistent with U.S. Public Health Services Guidelines (www.aidsinfo.nih.gov/).
2.3. **Problem List**

A central “problem list,” separate from progress notes, should be created, including prioritized problems for case management services and containing updates on:

2.3.1. Annual risk assessment for TB and PPD tests as necessary.

2.3.2. Examinations by dentist, as indicated.

2.3.3. Ongoing/unresolved issues or problems, either medical or psychosocial.

2.3.4. Referral to case management if indicated.

3. **Administrative Standards of Care**

In addition to demonstrating competency in the provision of HIV-disease-specific care, HIV clinical service programs must show evidence that their performance follows administrative norms for ambulatory care. This section describes the agency’s minimum administrative requirements. Agencies and individuals may exceed these standards.

3.1. **Licensing, Knowledge, Skills and Experience**

Providers should be able to document the following in terms of licensing, knowledge and experience.

3.1.1. Current organizational licensure (and/or applicable certification) and professional licensure of all staff delivering clinical health services.

3.1.2. Professional supervision of all staff.

3.1.3. Staff training and/or experience with the medical care of children with HIV, including continuing educational units awarded for participation in pediatric HIV seminars.

3.1.4. Staff who are culturally sensitive and experienced and/or linguistically able to provide services to the minority populations who are most impacted by HIV/AIDS.

3.2. **Client Rights and Confidentiality**

Providers must be able to document the following in terms of patients’ rights and confidentiality.

3.2.1. The protection of patient rights and clarification of patient responsibilities.

3.2.2. Assurance of patient confidentiality with regard to medical information transmission maintenance and security.

3.2.3. Copies of patient rights and the agency’s confidentiality policy shall be given to all families and/or caretakers.

3.3. **Access, Care and Provider Continuity**

Providers should be able to document the following in terms of access, care and provider continuity.

3.3.1. The time-appropriate delivery of services, including 24-hour call coverage.
3.3.2. Mechanisms for urgent care evaluation and/or triage.

3.3.3. Mechanisms for inpatient care (or referral) and return to ambulatory care.

3.3.4. Care services that include (either directly or by referral):
   3.3.4.1. Subspecialties, including but not limited to: gastroenterology, neurology, psychiatry, ophthalmology, dermatology, and neuro-developmental assessment.
   3.3.4.2. Social work and case-management services.
   3.3.4.3. Substance-abuse evaluations and treatment services (adolescent).
   3.3.4.4. Reproductive counseling with and antiretroviral options for pregnant teens.
   3.3.4.5. Information for persons with inherited coagulopathies and referral to the local federally funded hemophilia treatment center.
   3.3.4.6. Medication readiness and adherence counseling.

3.3.5. Nutritional counseling from a registered dietician or experienced staff.

3.3.6. Continuity with referring providers.

3.3.7. Education of the patient, family, significant other and/or caregiver.

3.3.8. Access to clinical investigations.

3.4. **Agency Responsibilities**

The provider agency shall also adhere to certain service standards, as follows:

3.4.1. An intake and eligibility screening process that assesses HIV status or exposure risk for infants, and that establishes family income, insurance and residence.

3.4.2. A consumer advisory board that meets at least quarterly with representation from the families served by the clinical program. Documentation of CAB activities must be maintained.

3.4.3. A system for providing information and referrals to families when needed services are not available within the program. The agency or facility must show evidence of follow up on all referrals made.

3.4.4. Written criteria for receiving services, fee structure, intake process, discharge or transfer process and case closing procedures. The agency or facility must maintain documentation that shows this information was given to the families.

3.4.5. Written grievance policy and documentation that the policy has been given to each family or caretaker.

3.4.6. Copies of a signed release of information with the request for information documents.
3.5. **Quality Assurance**

Providers should have a written quality-assurance activity that identifies areas for improvement and the subsequent actions taken. The agency must show:

3.5.1. An overall mechanism or quality-assurance plan designed to monitor both the appropriateness and effectiveness of all services provided.

3.5.2. Documentation of care plan reviews, both peer and supervisor.

3.5.3. Documentation of utilization review.

3.5.4. Documentation of the most recent site visit by the administrative agency.

3.5.5. Documentation of action plans that address corrective actions and/or improvement in outcomes based on best practices.

3.5.6. Documentation of periodic data and narrative reports to the administrative agency.

3.5.7. Documentation of a process to solicit information on client satisfaction with services (at least annually).

3.5.8. Documentation that service meets the service category standards and/or any applicable professional or federal practice standards.

4. **Summary**

Not applicable.

5. **Recommendations**

Not applicable.

6. **References and Further Reading**


7. **Appendices**

Not applicable.