Pregnant women living with HIV often have reduced engagement in HIV care and lower adherence to antiretroviral medications after delivery. This checklist is designed to assist clinical providers and members of the multidisciplinary healthcare team to identify risk factors that can be associated with poor engagement and retention in HIV care in order to connect the pregnant or postpartum woman to appropriate support services. The assessment tool should be used during pregnancy and continued postpartum in obstetric, HIV, and pediatric care settings. **Check all risk factors that apply** and use the comments section to document additional information to assist in developing a plan of care**.**

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| --- | --- | --- |
| **HIV diagnosis and care** |  | **Comments** |
| New HIV diagnosis during pregnancy |  |  |
| Late HIV diagnosis (in 3rd trimester/postpartum) |  |  |
| Current, detectable HIV RNA (viral load)1 |  |  |
| History of detectable HIV RNA in the past year |  |  |
| Lack of engagement in HIV care prior to or during pregnancy, e.g., 2 or more consecutive missed visits for HIV care |  |  |
| Pregnant woman with perinatally acquired HIV infection |  |  |
| Has an HIV positive child |  |  |
| **Obstetric Care** |  | **Comments** |
| Entry into prenatal care in the 3rd trimester |  |  |
| Insufficient prenatal care2 |  |  |
| Infant feeding concerns, wants to breastfeed |  |  |
| Pre-term delivery |  |  |
| OB, HIV and/or Pediatric care not co-located |  |  |
| **Social and System** |  | **Comments** |
| Partner/family/key support network unaware of HIV diagnosis |  |  |
| Lack of social support network |  |  |
| Non-English speaking |  |  |
| Undocumented legal status |  |  |
| Low health literacy |  |  |
| Lack of transportation |  |  |
| Unstable housing/homeless |  |  |
| Intimate partner violence |  |  |
| History of involvement with child protective services |  |  |
| Recently incarcerated (mother or partner) |  |  |
| Exchanging sex for money or drugs |  |  |
| Inability to pay copays or out of pocket expenses, underinsurance |  |  |
| Medicaid during pregnancy only, loses coverage postpartum |  |  |
| Mother/child receiving services in different jurisdictions and or funding sources, i.e., across state or county lines |  |  |
| **Mental Health/Behavioral Disorder** |  | **Comments** |
| Current or previous history of depression |  |  |
| Psychological and/or mental illness NOT adequately managed |  |  |
| Current or recent past history of substance abuse/alcohol abuse |  |  |
| Developmental delay(s) or intellectual disability |  |  |
| **Other Factors3** |  | **Comments** |
|  |  |  |
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|  |  |  |
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1Does not refer to transient low level increases in HIV RNA (isolated blips to less than 400 copies/mL)

2 Fewer than 5 visits before 37 weeks or fewer than 8 visits for those who are 37+ weeks

3Use to add other, individualized factors important to case management and retention in care during and after pregnancy

The checklist is based on available data about factors that have been associated with decreased adherence and retention in HIV care postpartum, as well as data from other studies about retention in HIV care and experience in clinical practice. At present, the tool is not designed to be scored to calculate various levels of risk for reduced postpartum retention in care. Healthcare providers should use the checklist with individual patients to recognize existing risks and to plan appropriate supportive care and case management to address those factors that would respond to these interventions. The goal is to provide a clinical resource to assist clinicians in their efforts to improve postpartum retention in HIV care among women living with HIV. General guidance about levels of services for women with varying needs is provided below.

**Routine postpartum follow-up support:** Suggested for postpartum women established in care who:

* Were established in HIV care prior to pregnancy and are going back to their previous HIV care provider after their pregnancy
* Are in systems where the OB provider can readily communicate with the HIV provider
* Have undetectable HIV RNA during pregnancy or at time of delivery

Make follow up appointments prior to delivery. Schedule OB follow up visits at 2 to 6 weeks postpartum. Schedule follow up visit with long term HIV provider within 2-4 weeks post-partum, before the woman is discharged from OB care. Confirm that HIV provider appointment is kept, preferably through outreach to the provider.

**Enhanced postpartum follow-up support:** Suggested for women with issues that will respond to interventions through case management, patient navigation, or other support services:

* Newly diagnosed during pregnancy
* Intermittent adherence to antiretroviral therapy
* Detectable HIV RNA at delivery
* Lack of disclosure
* Concerns about formula feeding, desire to breast feed

Discuss potential barriers and facilitators to postpartum engagement in care. Consider linking to case management and other support services. Consider adding “At risk for PP lost to follow-up” to the problem list in the medical record.

**Intensive case management and patient navigation:** Suggested forwomen with ongoing barriers to care that are difficult to address and may not respond to usual levels of case management and navigation.

* Consider for any active mental illnesses that are not adequately managed, active substance abuse, or homelessness
* Mothers with perinatally acquired HIV infection

More time, effort, and resources will be required to care for these challenging situations. Interventions may require outreach through home/community visits and strong/intensive communication with community agencies. Providers may need to use novel interventions and to think “outside the box”.