Michigan Department of Health and Human Services (MDHHS)
Perinatal Human Immunodeficiency Virus (HIV), Hepatitis B, Hepatitis C, and Syphilis Testing and Reporting Guidelines

For prenatal care (PNC), labor and delivery (L&D), and emergency department (ED) medical providers.

Physicians and other health care professionals providing medical treatment to birthing women are required, at the time of initial prenatal screening and examination, and during the third trimester, and at delivery in absence of previous testing results to test for **HIV**, **hepatitis B,** and **syphilis**, unless the birthing woman refuses to be tested or the provider deems the tests are medically inadvisable (required under section 333.5123 of Michigan's Public Health Code, Act No. 368 of the Public Acts of 1978. Amended 12/2018). MDHHS recommends universal screening for syphilis at delivery for all birthing women rather than a risk-based approach to syphilis testing, in accordance with current American College of Obstetricians & Gynecologists (ACOG) guidance. Universal hepatitis C screening is recommended for all pregnant women during each pregnancy, in accordance with CDC and ACOG guidance.

Health care facilities should have written policies and procedures, as well as standing orders in place to ensure that HIV, hepatitis B, hepatitis C, and syphilis testing is completed.

A separate consent form for an HIV test is not required. A test subject or his or her authorized representative who provides general informed consent for medical care is considered to have consented to an HIV test. Medical providers must document any declination of testing in the patient's medical record (per section 333.5133 of Michigan's Public Health Code, Act No. 368 of the Public Acts of 1978. Amended 2018).

A physician who orders a test or a health facility that performs a test **shall provide accurate testing information** to the test subject both before and after the test is administered.

PRENATAL, L&D, ED TESTING	HIV	HEPATITIS B	SYPHILIS	HEPATITIS C
All birthing women in first trimester of pregnancy:	**Should be tested for HIV (4th generation Ag/Ab assay), hepatitis B surface antigen (HBsAg), hepatitis C antibody, and syphilis (treponemal and nontreponemal tests), as soon as possible in the first trimester of pregnancy, as part of routine prenatal care.** (e.g., upon diagnosis of pregnancy at any healthcare facility; at the initial prenatal visit). **All positive screening tests must be confirmed with an appropriate confirmatory test.** **Consult** an infectious disease specialist, or experienced perinatal provider, promptly upon confirmation of a positive test result.			
All birthing women in third trimester of pregnancy:	**Test in the third trimester, and per MDHHS recommendations, between 28- 32 weeks,** regardless of perceived risk and/or previous negative test result. MDHHS recommends that testing is performed as early in the third trimester (28 weeks) as possible to allow for adequate treatment and best outcomes for the infant. **All positive screening tests must be confirmed with an appropriate confirmatory test**. **Consult** an infectious disease specialist, or experienced perinatal provider, promptly upon confirmation of a positive test result. **Consult** a pediatric infectious disease specialist upon confirmation of HIV infection in a birthing woman so that a care plan for the infant can be developed prior to the onset of labor. CDC.gov/pregnancy-hiv-std-tb-hepatitis/php/screening			**Birthing women with ongoing risk factors who were tested for hepatitis C early in pregnancy** should undergo repeat testing later in pregnancy to identify those who acquired hepatitis C infection later in pregnancy. Testing may also be performed as part of the mid-trimester laboratory work for STI and gestational diabetes mellitus (GDM) screening (24 to 28 weeks gestation).
Birthing women who are at high risk for infection: For example, birthing women who: ▪ Have a sexually transmitted infection (STI) during pregnancy. ▪ Inject drugs or share drug equipment. ▪ Have a sex partner who injects drugs. ▪ Have a partner who has sexual contact with a man. ▪ Exchange sex for money or drugs. ▪ Have an HIV-infected partner. ▪ Have an HBsAg-positive household member or sex partner. ▪ Have a new partner, or more than one sex partner, during the pregnancy.	**Test at any time and as often as necessary** regardless of previous negative test results. **Test upon admission for delivery** regardless of previous negative test results. **Test birthing women who have signs or symptoms consistent with acute HIV infection using a plasma RNA test in conjunction with an HIV antibody test.** **Consult** an infectious disease specialist, or experienced perinatal provider, promptly upon confirmation of a positive test result. **Consult** a pediatric infectious disease specialist upon confirmation of HIV infection in a birthing woman so that a care plan for the infant can be developed prior to the onset of labor. ACOG recommends triple panel screening (HBsAg, anti-HBs, and total anti-HBc) for all pregnant women who do not have a documented negative triple screen result after age 18 years or who have not completed a hepB vaccine series, or in patients with ongoing known risks for hepatitis B infection, regardless of vaccination status or history of testing.			
No/late prenatal care, incomplete screening, or ongoing risk factors such as: ▪ Have no record of HBsAg testing. ▪ Have no record of hepatitis C Antibody testing. ▪ Have no record of 3rd trimester HIV or syphilis test result. ▪ Have no prenatal care. ▪ Present in the immediate postpartum period (24 hours).	**Test STAT with rapid or expedited point of care testing.** Every birthing woman's medical record should include documentation of testing or declination of testing and reason for refusal. All positive screening tests should be reviewed and confirmed promptly with an infectious disease specialist or HIV experienced perinatal provider. A pediatric infectious disease specialist should be notified about the birthing woman's treatment history and viral load so that a care plan can be initiated prior to delivery. **All positive screening tests must be confirmed with an appropriate confirmatory test.** Hospitals must have procedures in place to report the confirmatory test results and HIV infection status to all birthing women they test. A pediatric infectious disease specialist and MDHHS should be notified of any suspected HIV, syphilis, hepatitis B, or hepatitis C infection in a birthing woman so that a care plan for the infant can be developed prior to delivery. Contact information for MDHHS can be found at the bottom of this document. **No birthing woman should leave the hospital unless the maternal serologic status has been documented.**			

MDHHS Michigan Department of Health & Human Services

Michigan Department of Health and Human Services (MDHHS)
Perinatal Human Immunodeficiency Virus (HIV), Hepatitis B, Hepatitis C, and Syphilis Testing and Reporting Guidelines

For prenatal care (PNC), labor and delivery (L&D), and emergency department (ED) medical providers.

PRENATAL, L&D, ED TESTING	HIV	HEPATITIS B	SYPHILIS	HEPATITIS C
Maternal Treatment	**Prenatal Care Providers:** An appropriate antiretroviral treatment plan should be initiated promptly upon consultation with an infectious disease specialist or HIV experienced perinatal provider. **L&D and ED:** Hospitals must have mechanisms in place to provide immediate initiation of appropriate antiretroviral prophylaxis - antepartum, intrapartum and/or at the onset of delivery - based on any reactive rapid or expedited HIV test result, without awaiting results of a confirmatory test. People with HIV should receive evidence-based, patient-centered counseling to support their decisions on infant feeding. People with HIV who have consistently suppressed viral loads throughout pregnancy should be informed of the risks and benefits of breastfeeding, chest feeding, formula feeding, and the use of pasteurized donor human milk to support their decision making.	**Birthing women who are HBsAg-negative but are at high risk** of acquiring HBV should be offered the hepatitis B (hepB) vaccine series. **Birthing women who are HBsAg positive**, need to be referred to an infectious disease specialist and should be tested for HBV DNA quantitatively to guide the use of maternal antiviral therapy to prevent perinatal transmission.	**Birthing women who test positive for syphilis** should receive penicillin G in accordance with current CDC STI Treatment Guidelines.	**Birthing women who test positive for HCV** should receive treatment postpartum. Hepatitis C treatment should be postponed during breastfeeding due to lack of studies on nursing while on hepatitis C treatment.
Infant Treatment	**Rapid HIV testing is recommended for all infants whose biological birthing woman has not been tested.** Inform the person legally authorized to provide consent for the infant, that rapid HIV testing is recommended for infants whose HIV exposure is unknown. **HIV exposed infants** should be started on single or multi drug antiretroviral prophylaxis as soon as possible after birth. Preferably **within 6-12 hours of delivery.** **Postnatal infant prophylaxis** is recommended with antiretroviral medication(s). The number of medications (1 to 3) and duration recommended (2 to 6 weeks) are based on risk factors of HIV transmission. If there are any questions on infant risk level, please consult pediatric HIV specialists (listed below). Hospitals must have mechanisms in place to: • Provide zidovudine, as well as lamivudine and nevirapine, if indicated, in syrup form to HIV-exposed infants in-house. • Ensure that antiviral medications in syrup form are available to the infant after discharge.	**All infants** weighing at least 2,000 g should receive hepB vaccine **within 24 hours of birth**. Infants weighing less and those born to HBsAG-negative women negative should have first vaccine dose at time of hospital discharge or age 1 month, whichever is first. **Infants born to HBsAg-positive birthing women and women with unknown HBsAG status, including safely surrendered babies,** should receive hepB vaccine and hepatitis B immune globulin (HBIG) **within 12 hours of birth**, followed by 2-3 more doses of hepB vaccine and post-vaccination serology 3-6 months after series completion.	**No infant should leave the hospital** unless the maternal serologic status has been documented. Infants exposed to **syphilis** should be evaluated (**including a nontreponemal test**), as they may need treatment with penicillin G, according to current CDC STI treatment guidelines, immediately after birth.	Infants born to birthing women with current (has detectable HCV RNA) or probable (anti-HCV reactive, HCV RNA results are not available) HCV infection should be tested for hepatitis C at 2-6 months of age with an HCV RNA test. If previously not been tested: • Infants ages 7-17 months with perinatal exposure to HCV should receive HCV RNA testing. • Infants and children ages 18 months or older with perinatal exposure to HCV should receive anti-HCV with reflex to HCV RNA testing. HCV antibody testing should only be conducted in children greater than 18 months old, and if positive, should be confirmed with an HCV RNA test. Infants and children with detectable HCV RNA should be managed in consultation with a health care provider with expertise in pediatric hepatitis C management for related screenings, preventive services, interventions, and regular follow-up. Children who test positive should be retested with a NAT for HCV RNA before beginning treatment, which can be started as early as age 3 years.
Documentation	**Refusal to test, refusal to accept treatment, and a description of any required perinatal tests that were not performed for any reason, must be documented in the birthing woman's medical record.** **All test results and treatment should be recorded** in both the birthing woman's and the baby's medical records, along with the date of testing, result, or refusal.			
Reporting	People who test positive for **HIV, hepatitis B, hepatitis C,** and/or **syphilis** must be reported within **24 hours,** of diagnosis or discovery, to the local health department in the county of which the patient resides. **Please also call MDHHS at 313-456-1586.** (Per section 333.5111 of Michigan's Public Health Code, Act No. 368 of the Public Acts of 1978, as amended)			

Consultation concerning implementation of these guidelines can be obtained from:

- **Michigan HIV and HCV Consultation Program at Henry Ford Health System**, urgent questions (24/7): 313-575-0332
- **Midwest AIDS Training and Education Center Michigan (provider education for HCV and HIV):** 313-408-3483 or matecmichigan.org
- **National Perinatal HIV Consultation and Referral Service:** 888-448-8765
- **Michigan Department of Health and Human Services (MDHHS) Questions and Reporting**
  - **Perinatal HIV:** 313-434-4419
  - **Congenital syphilis:** 313-316-4680
  - **Perinatal hepatitis B:** 517-242-8319
  - **Perinatal hepatitis C:** 517-335-8165
- **Minerva Galang, MD Mercy Health Infectious Disease:** 616-397-6586
- **Rosemary Olivero, MD Helen DeVos Children's Hospital, Grand Rapids**: 616-479-0883
- **Theodore Jones, MD, FACOG Corewell Health Dearborn Maternal/Fetal Medicine:** 313-503-1873
- **Eric McGrath, MD, Wayne State University School of Medicine - Department of Pediatrics, Division of Infectious Diseases and Prevention:** 313-505-4005

Resources: Additional perinatal resources including case report forms, Michigan law requirements and more detailed guidance and recommendations for perinatal testing can be found at Michigan.gov/PerinatalHIVSTI.

MDHHS Michigan Department of Health & Human Services