

Practice Guidelines for the Care of Persons Living with HIV/AIDS

Ryan White HIV Treatment Extension Act of 2009

San Diego County

In conjunction with United States (U.S.) Public Health Service (PHS) guidelines and accepted community practices, the San Diego County HIV Planning Group's Medical Standards and Evaluation Group recommends the following practice guidelines for the management of human immunodeficiency virus (HIV) infection in patients enrolled in the Ryan White Primary Care Program of San Diego County.

Antiretroviral therapy (ART) and opportunistic infection (OI) prophylaxis (primary and secondary) are recommended in accordance with the most recent PHS guidelines. Guidelines may have been updated since the versions listed below; current versions are available at <https://clinicalinfo.hiv.gov/en/guidelines>.

For San Diego County Ryan White Clinics, chart reviews and performance assessments conducted on behalf of the County of San Diego Health and Human Services Agency (HHS) – Division of Public Health Services – HIV, STD, and Hepatitis Branch (HSHB) will be based upon these guidelines.

A. Guidelines for Staging and Baseline Evaluation (recommended to be completed within the first two visits)

- 1) Complete history, to include at least the following:
 - a. *General background:*
 - Race/ethnicity
 - Current gender identity
 - Sex assigned at birth
 - Housing status
 - Family history
 - Social history
 - Travel history
 - Country of birth
 - b. *Current/lifetime sexual history: (See Appendix A for example)*
 - Sexually transmitted infection/disease (STI/STD) history during lifetime and/or last 5 years
 - Relationship status
 - Detailed sexual history
 - Partner(s), including HIV status and history of pre-exposure prophylaxis (PrEP) use
 - Exposure sites – anorectal, genital, oropharyngeal
 - Use of condoms
 - c. *Current/lifetime substance use history:*
 - Injection drug use (IDU), during lifetime and/or last 5 years
 - Non-injection drug use, during lifetime and/or last 5 years
 - Alcohol and/or drug treatment history
 - Sexual activity under the influence of substances
 - Tobacco use, during lifetime and/or last 5 years
 - d. *HIV care history:*
 - HIV status, including recent/historical CD4+ T-cell count/HIV-1 viral load
 - Prior and current antiretroviral regimens
 - Resistance test results (if available)
 - Current prophylaxis
 - Prior HIV-related complications
 - e. *General medical history:*
 - Immunizations

- Hepatitis history
 - Tuberculosis (TB) risk
http://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/tuberculosis_control_program/SanDiegoRiskAssessment-Adults.pdf
 - Reproductive history (persons assigned female at birth), including parity, last menstrual period (LMP), and method of birth control
 - Current allergies
 - Other current medications
 - Significant childhood illnesses
 - Surgical history
 - Mental health history, past/current mental health conditions, symptoms of depression, and psychiatric medications
 - Other medical history
- 2) Review of symptoms and general physical exam, including height, weight, temperature, blood pressure, pulse, respiratory rate, general appearance, skin, head, eyes, ears, nose and throat (HEENT), ophthalmoscopy, chest, heart, lungs, abdomen, rectum, anoscopy (if anorectal symptoms), pelvic (persons assigned female at birth), breasts, genitalia, extremities, lymph nodes, mental status, nervous system including reflexes
- 3) Laboratory tests
- a. For the current list of recommended labs and periodicity, please refer to [PHS Guidelines for Laboratory Testing for Initial Assessment and Monitoring of Patients with HIV Receiving Antiretroviral Therapy](#).
 - b. STI Testing
 - Should be performed at baseline and at least annually thereafter for sexually active clients, more frequently (i.e., every three to six months) if indicated based upon the client's sexual practices.
 - Syphilis serology
 - Gonorrhea/Chlamydia – Perform three-site testing (i.e., urogenital, throat, rectum) using nucleic acid amplification testing (NAAT). If antibiotic-resistant *Neisseria gonorrhoeae* is suspected, obtain *N. gonorrhoeae* culture from all exposure sites.
 - Trichomoniasis – Screening with NAAT should be performed annually for persons having vaginal sex.
 - Anal Pap test (optional) – See **Section G – Anal Cancer Screening**.
 - Resources:
 - [Centers for Disease Control and Prevention \(CDC\) Recommendations for Providing Quality STD Clinical Services, 2020](#)
 - [CDC Interim Guidance for STD Care and Treatment During Disruption of Clinical Services](#)
 - [CDC STD Treatment Guidelines, 2015](#)
 - [Updated CDC Gonorrhea Treatment Recommendations, 2020](#)
 - [CDC Recommendations for the Laboratory-Based Detection of *Chlamydia trachomatis* and *Neisseria gonorrhoeae*, 2014](#)
 - c. TB Testing
 - Annual screening in the form of Annual Risk Assessment:
http://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/tuberculosis_control_program/SanDiegoRiskAssessment-Adults.pdf
 - Annual screening using purified protein derivative (PPD) or interferon-gamma release assay
 - If screening test is positive, the patient should have a chest x-ray.
 - Chest x-ray: At least one should be documented in the medical record if the individual has a history of TB or a positive screening test.
 - d. Viral Hepatitis Testing
 - Hepatitis B screening should be performed by testing for hepatitis B surface antibody (HBsAb), surface antigen (HBsAg), and antibody to core antigen (anti-HBc or HBcAb). Those who are susceptible to infection should be vaccinated against Hepatitis B Virus (HBV) (see **Section C – Guidelines for Immunization**). Patients who are negative for HBsAg and

HBsAb but positive for anti-HBc should be screened for chronic HBV infection by determination of HBV deoxyribonucleic acid (DNA). Those without evidence of chronic infection should consider vaccination.

<https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-opportunistic-infection/hepatitis-b-virus-infection?view=full>

- Hepatitis C screening with Hepatitis C Virus (HCV) antibody or, if recent (i.e., within last six months) infection is suspected, the patient has advanced immunodeficiency (CD4 count < 100 cells/mm³), or the patient has a history of successfully treated or spontaneously cleared HCV infection, ribonucleic acid (RNA) testing should be performed at baseline and at least annually for persons with ongoing risk factors (e.g., IDU) and sexually active men who have sex with men (MSM). HCV RNA should be ordered for all patients with a positive HCV antibody test to assess for active HCV disease.

<https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-opportunistic-infection/hepatitis-c-virus-infection?view=full>

e. Other Testing:

- Measles antibody titer – All persons with HIV born in 1957 or after should be tested for immunity to measles by measuring antibody titers. The measles, mumps, and rubella (MMR) vaccine should be given to persons with CD4 ≥ 200 cells/mm³ born in or after 1957 who have not received the vaccine or do not have immunity based on laboratory testing (see **Section C – Guidelines for Immunization**).

4) Appropriate referrals, including but not limited to:

- Treatment adherence counseling
- Ryan White dental program (recommended annually)
- Ophthalmologist if CD4 < 50 cells/mm³ (recommended)
- Case management (if eligible)
- Medical nutrition therapy
- Clinical trials
- Mental health
- Substance use treatment
- Partner services/PrEP if client has not achieved sustained viral suppression

For a list of currently funded Ryan White Service Providers, please visit:

[HIV/AIDS Care and Services Resources \(sandiegocounty.gov\)](http://HIV/AIDS%20Care%20and%20Services%20Resources%20(sandiegocounty.gov))

B. Guidelines for Plasma HIV RNA (i.e., Viral Load) Measurements and CD4 Counts

<https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/plasma-hiv-1-rna-viral-load-and-cd4-count-monitoring?view=full>

- 1) HIV-1 RNA (i.e., Viral Load) – should be performed upon entry to care, before initiation of ART (if initiation of ART is deferred after entry to care), and within 2-4 weeks but no later than 8 weeks after ART initiation. After initiation or modification of ART, repeat at 4-8-week intervals until undetectable. Continue to monitor every 3-4 months during the first 2 years of ART, and then frequency can be decreased to every 6 months if the viral load is consistently undetectable for two years and the CD4 is > 500 cells/mm³.
- 2) CD4+ T-cell Count (i.e., CD4 Count) – should be performed upon entry to care and three months after initiation of ART (every 3-6 months in patients who defer ART). After initiation or modification of ART, repeat every 3-6 months during the first 2 years or if the CD4 count is < 300 cells/mm³ or if there is any viremia while on ART. May monitor every 12 months if the patient has consistently been on ART with a suppressed viral load and CD4 count 300-500 cells/mm³. Optional once CD4 is consistently > 500 cells/mm³ and viral load has been undetectable for > 2 years.

C. Guidelines for Immunization

[Adult Immunization Schedule by Vaccine and Age Group | CDC](#)

[Vaccines Indicated for Adults Based on Medical Indications | CDC](#)

- 1) Should be offered as soon as possible after initial evaluation at recommended doses.
- 2) Viral loads should not be measured within three weeks of an immunization.
- 3) Pneumococcus (both types), influenza, tetanus, Hepatitis B (if not immune), Hepatitis A (if not immune), human papillomavirus (HPV), meningococcal

- 4) Influenza vaccine: recommended yearly with trivalent inactivated vaccine (live attenuated vaccine is contraindicated in persons living with HIV or PLWH).
- 5) HPV: Recommended for all PLWH through age 26 years as a three-dose series, regardless of the age at initial vaccination. Vaccination may be considered, based on shared clinical decision-making, for persons aged 27-45 years.
<https://www.cdc.gov/mmwr/volumes/68/wr/mm6832a3.htm>
- 6) Varicella zoster: Two doses of the Shingrix vaccines should be given to patients over the age of 50 years with CD4 count >200 cells/mm³.
- 7) Hepatitis Vaccines:
 - a. **Hepatitis B:** Recommended in persons with negative serology or isolated positive core antibody (i.e., negative surface antigen and antibody). Double dosing (i.e., 40µg) of single-antigen three-dose vaccines is recommended to increase seroconversion rates. For those patients who do not seroconvert after the first series, a second series is recommended. If these persons do not seroconvert, they are unlikely to respond to a third series. The safety and efficacy of the two-dose vaccine has not been evaluated in PLWH but is an option if a two-dose regimen is preferred. <https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-opportunistic-infection/hepatitis-b-virus-infection?view=full>
 - b. **Hepatitis A:** Seroconversion rates are likely related to CD4 counts. The vaccine may be given in persons who are seronegative. However, if there is no response and the CD4 counts are less than 500 cells/mm³, persons can receive a repeat series when CD4 counts are higher.
- 8) Pneumococcal: Both the 13-valent pneumococcal conjugate vaccine (PCV13) and the 23-valent pneumococcal polysaccharide vaccine (PPV23) are recommended, with the final dose of PPV23 given at ≥65 years of age and ≥5 years after previous PPV23 doses given before age 65 years. For specific recommendations regarding timing of PCV13 and PPV23 doses, see <https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-opportunistic-infection/community-acquired-pneumonia-cap?view=full>.
- 9) Meningococcal: Vaccination against serogroups A, C, W, and Y is recommended for all persons living with HIV aged ≥2 years. <https://www.cdc.gov/mmwr/volumes/65/wr/mm6543a3.htm>. Vaccination against serogroup B is recommended for persons aged ≥10 years who are at increased risk for serogroup B meningococcal disease due to certain underlying conditions or a serogroup B outbreak. HIV disease is not one of the underlying conditions for which serogroup B vaccination is recommended. Serogroup B vaccination may be considered for adolescents and young adults aged 16-23 years on the basis of shared decision-making. <https://www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm>
- 10) Tetanus vaccines: Recommended every 10 years. Recommend that the next booster contain pertussis booster (Tdap) (make sure the patient has had the pertussis vaccine)
- 11) Live Vaccines (Live attenuated influenza vaccine, Varicella or Zoster vaccine, Vaccinia (small pox), Yellow Fever, Live Oral Polio, Measles*, Typhoid) are contraindicated in persons with severe immunosuppression based on the person's age (per Advisory Committee on Immunization Practices or ACIP): CD4<750 for those younger than 12 months, <500 for those aged 1-5 years, and <200 for those >6 years old.
*The MMR vaccine should be given to persons with CD4 ≥200 cells/mm³ born in or after 1957 who have not received the vaccine or do not have immunity based on laboratory testing.
- 12) Booster doses as recommended by CDC guidelines.

D. Treatment:

- 1) All PLWH should receive ART, regardless of CD4 count, to reduce morbidity and mortality, improve health outcomes, and prevent transmission of HIV to others.
- 2) Whenever possible, treatment should be initiated immediately (or as soon as possible) after diagnosis.
 - a. Same-day treatment should be offered if there are no medical indications to defer therapy (e.g., signs/symptoms of intracranial OI).
 - b. If treatment is offered before the results of treatment-naïve genotype are available, an integrase inhibitor-based regimen is recommended.

- 3) All PLWH should be informed that maintaining a plasma HIV RNA (viral load) of <200 copies/mL, including any measurable value below this threshold value, with ART prevents sexual transmission of HIV to their partners. Patients may recognize this concept as Undetectable = Untransmittable or U=U.
- 4) Guidelines on antiretroviral treatment regimens can be found at <https://aidsinfo.nih.gov/guidelines>.
- 5) At the time of revision, an extended-release, injectable drug regimen (coformulation of cabotegravir and rilpivirine) was approved by the Food and Drug Administration (FDA) to replace the current antiretroviral regimen for patients with viral suppression on a stable ART regimen without history of treatment failure and with no known or suspected resistance to either agent. Long-acting injectable ART may be considered for eligible patients and should be administered according to Department of Health and Human Services guidelines: <https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/hhs-adults-and-adolescents-antiretroviral-guidelines-panel>.
- 6) For patients with HBV coinfection, as determined by a positive HBsAg or HBV DNA test result, tenofovir disoproxil fumarate or tenofovir alafenamide, plus either emtricitabine or lamivudine, should be used as part of the ART regimen to treat both HBV and HIV.
- 7) Patients with HCV coinfection should be managed based on the most up-to-date recommendations (<http://www.hcvguidelines.org>). In general, the goals of therapy, treatment regimen, and monitoring parameters for HIV/HCV-coinfected patients are similar to those recommended for HCV-monoinfected patients.

E. Metabolic and Other Noncommunicable Comorbidities Associated with HIV, ART, and Aging

- 1) The availability of highly effective HIV treatment has resulted in longer life expectancy for PLWH and a larger proportion of PLWH who are aged 50 years or older.
- 2) For all PLWH aged 50 years or older, providers should closely monitor for and promptly evaluate signs or symptoms of the following conditions that are associated with advanced age, long-term HIV infection, ART, or a combination of these:
 - a. Cardiovascular disease and associated risk factors (e.g., hyperlipidemia, glucose intolerance or diabetes mellitus, hypertension, smoking)
 - b. Osteoporosis and bone mineral density loss
 - c. Hypogonadism
 - d. Neurocognitive decline
 - e. Mental health conditions, such as depression
 - f. Polypharmacy
 - g. Kidney disease
 - h. Certain non-acquired immune deficiency syndrome (AIDS)-related cancers
- 3) Specific recommendations regarding metabolic and noncommunicable comorbidities include:
 - a. Check lipid levels prior to and within 1-3 months after starting ART. Patients with abnormal lipid levels should be managed according to national guidelines.
 - b. Random or fasting blood glucose and hemoglobin A1c (HbA1c) should be obtained prior to starting ART. If random glucose is abnormal, fasting glucose should be obtained. After ART initiation, only plasma glucose criteria should be used to diagnose diabetes. Patients with diabetes mellitus should have an HbA1c level monitored every 6 months with an HbA1c goal of <7%.
 - c. Baseline bone densitometry (DXA) screening for osteoporosis in post-menopausal women and men aged ≥50 years. Screening for transgender persons should follow national recommendations based on sex assigned at birth and individualized risk of osteoporosis.
 - d. Testosterone replacement therapy for cisgender men should be prescribed with caution and only in those with symptomatic hypogonadism diagnosed based on the presence of symptoms plus low serum testosterone documented on two separate morning lab tests.

Primary Care Guidance for Persons with Human Immunodeficiency Virus: 2020 Update by the HIV Medicine Association of the Infectious Diseases Society of America:

<https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciaa1391/5956736>

F. Additional Guidelines for Care of Persons Assigned Female at Birth

- 1) Guidelines for Cervical Neoplasia (modified Algorithm 6 of AHCP 94-0573):

<https://hab.hrsa.gov/sites/default/files/hab/About/clinical-quality-management/adolescentadultmeasures.pdf>

- a. Age <21 years: Pap test within one year of sexual activity and no later than age 21
 - b. Age 21-29 years: Pap test at time of HIV diagnosis. Repeat yearly for three years. If all tests are normal, repeat Pap test every three years thereafter.
 - c. Age <30 years: No HPV testing should be performed unless abnormalities are found on Pap test.
 - d. Age ≥30 years: Pap only (same as for 21-29 years) or Pap with HPV testing. If both tests are negative, repeat Pap with HPV test every three years thereafter.
 - e. If three consecutive Pap tests are normal, then a follow-up test should be done every three years.
 - f. Patients with abnormal Pap smears or a history of an untreated abnormal Pap smear should be referred for colposcopy and should receive same management and follow-up as the general population.
Refer to American College of Obstetrics and Gynecology (ACOG) guidelines for management of abnormal cervical cancer screening results:
<https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2020/10/updated-guidelines-for-management-of-cervical-cancer-screening-abnormalities>
 - f. Cervical cancer screening should continue throughout the patient's lifetime and not, as in the general population, end at 65 years of age.
- 2) Annual mammograms initiated at age 50 or earlier depending on history
 - 3) Treatment for pregnant persons living with HIV – recommend referral to specialist (i.e., UCSD Maternal, Child & Adolescent Program)

G. Anal Cancer Screening:

- 1) Persons with a history of receptive anal intercourse or abnormal cervical Pap tests and all persons with genital warts should have an anal Pap test if access to appropriate referral for follow-up, including high-resolution anoscopy, is available.
- 2) Digital anorectal exam should be performed at least annually for asymptomatic persons.

H. PrEP and Partner Prevention Services – Assess HIV status of partner(s) and evaluate for PrEP referral for all patients living with HIV who have not achieved sustained viral suppression. Please note that Ryan White does not provide reimbursement for PrEP services for HIV-negative partners.

- 1) For guidelines regarding evaluation for and provision of PrEP, please refer to the U.S. PHS Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – 2017 Update. Please note that parts of these guidelines may be outdated, as a second agent (coformulation of emtricitabine and tenofovir alafenamide) received FDA approval for use as PrEP for persons assigned male at birth and may be preferred for certain patients at higher risk of renal and/or bone toxicity.
<https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf>
- 2) For guidelines regarding partner services for PLWH, please refer to the Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection.
<https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5709a1.htm>

I. HIV Management Guidelines for Transgender Individuals – Primary care of transgender PLWH should address the specific needs of this population and include careful attention to potential interactions between gender-affirming therapy and ART and/or OI prophylaxis medications. Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People, from the Center of Excellence for Transgender Health at the University of California, San Francisco, include recommendations for transgender individuals living with HIV and can be accessed at <https://transcare.ucsf.edu/guidelines>.

J. Interim Guidance for COVID-19 and PLWH – At the time of revision, the County of San Diego was in a state of emergency due to the rapidly evolving Coronavirus Disease 2019 (COVID-19) pandemic caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

While the limited data currently do not indicate that the course of COVID-19 in PLWH differs from that in persons without HIV, caution is warranted. Some people with HIV may have comorbidities (e.g., cardiovascular disease, lung disease, chronic smoking) that increase risk of more severe disease.

- 1) All patients should maintain on-hand at least a 30-day (and ideally a 90-day) supply of ART.
 - 2) Influenza and pneumococcal vaccinations should be kept up to date.
 - 3) COVID-19 vaccination should be administered based on CDC and Advisory Committee on Immunization Practices (ACIP) guidance.
<http://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html>.
 - 4) All patients should receive COVID-19 vaccination when eligible based on California state guidelines.
 - 5) Telephone and virtual visits for routine non-urgent care should be considered as an option to encourage retention in care.
 - 6) For further guidance, please refer to the U.S. PHS Interim Guidance for COVID-19 and Persons with HIV, available at <https://clinicalinfo.hiv.gov/en/guidelines/covid-19-and-persons-hiv-interim-guidance/interim-guidance-covid-19-and-persons-hiv>.
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Source Documents

1. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV (DHHS), accessed on April 19, 2021
<https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/whats-new-guidelines>
2. Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV (DHHS), accessed on April 19, 2021
<https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-opportunistic-infection/whats-new-guidelines>
3. San Diego Tuberculosis (TB) Risk Assessment, accessed on April 19, 2021
http://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/tuberculosis_control_program/SanDiegoRiskAssessment-Adults.pdf
4. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV – Laboratory Testing – Laboratory Testing for Initial Assessment and Monitoring of Patients with HIV on Antiretroviral Therapy (DHHS), accessed on April 19, 2021
<https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/tests-initial-assessment-and-follow?view=full>
5. Recommendations for Providing Quality Sexually Transmitted Diseases Clinical Services, 2020 (CDC), accessed on April 19, 2021
<https://www.cdc.gov/mmwr/volumes/68/rr/rr6805a1.htm#:~:text=CDC%20organized%20the%20recommendations%20for,STD%20or%20STD-related%20conditions>.
6. Interim Guidance for STD Care and Treatment During Disruption of Clinical Services (CDC), accessed on April 19, 2021
<https://www.cdc.gov/std/dstdp/DCL-STDTreatment-COVID19-04062020.pdf>
7. Sexually Transmitted Diseases Treatment Guidelines, 2015 (CDC), accessed on April 19, 2021
<https://www.cdc.gov/std/tg2015/tg-2015-print.pdf>
8. Update to CDC's Treatment Guidelines for Gonococcal Infection, 2020, accessed on April 19, 2021
https://www.cdc.gov/mmwr/volumes/69/wr/mm6950a6.htm?s_cid=mm6950a6_w
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- <https://www.cdc.gov/std/laboratory/2014labrec/2014-lab-rec.pdf>
10. Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV (DHHS) – Hepatitis B Virus Infection, accessed on April 19, 2021
<https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-opportunistic-infection/hepatitis-b-virus-infection?view=full>
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<https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-opportunistic-infection/hepatitis-c-virus-infection?view=full>
 12. County of San Diego HHS Ryan White Primary Care Program Information for Patients
https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/hiv_std_hepatitis_branch/HIVAIDSCareandServices/hiv-aids-care-and-services-resources.html#eligibility
 13. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV (DHHS) – Laboratory Testing – Plasma HIV-1 RNA (Viral Load) and CD4 Count Monitoring, accessed on April 19, 2021
<https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/plasma-hiv-1-rna-viral-load-and-cd4-count-monitoring?view=full>
 14. Recommended Adult Immunization Schedule for ages 19 years or older, United States, 2021 (CDC), accessed on April 26, 2021
<https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html>
 15. 2021 Recommended Adult Immunization Schedule by Medical Condition and Other Indications, United States, 2021 (CDC), accessed on April 26, 2021
<https://www.cdc.gov/vaccines/schedules/hcp/imz/adult-conditions.html>
 16. Human Papillomavirus Vaccination for Adults: Updated Recommendations of the Advisory Committee on Immunization Practices, 2019 (CDC), accessed on June 4, 2021
<https://www.cdc.gov/mmwr/volumes/68/wr/mm6832a3.htm>
 17. Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV (DHHS) – Community-Acquired Pneumonia, accessed on April 19, 2021
<https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-opportunistic-infection/community-acquired-pneumonia-cap?view=full>
 18. Recommendations for Use of Meningococcal Conjugate Vaccines in HIV-Infected Persons – Advisory Committee on Immunization Practices, 2016, accessed on April 19, 2021
<https://www.cdc.gov/mmwr/volumes/65/wr/mm6543a3.htm>
 19. Meningococcal Vaccination: Recommendations of the Advisory Committee on Immunization Practices, United States, 2020, accessed on June 4, 2021
<https://www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm>
 20. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV (DHHS) – HHS Adults and Adolescents Antiretroviral Guidelines Panel Recommendation for the Long-Acting Injectable Antiretroviral Regimen of Cabotegravir and Rilpivirine, accessed on April 19, 2021
<https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/hhs-adults-and-adolescents-antiretroviral-guidelines-panel>
 21. HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C – American Association for the Study of Liver Disease (AASLD) and Infectious Diseases Society of American (IDSA), accessed on April 19, 2021
<https://www.hcvguidelines.org>

22. Primary Care Guidance for Persons With Human Immunodeficiency Virus: 2020 Update by the HIV Medicine Association of the Infectious Diseases Society of America, accessed on April 19, 2021
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23. HIV/AIDS Bureau Performance Measures for Cervical Cancer Screening March 2016
<https://hab.hrsa.gov/sites/default/files/hab/About/clinical-quality-management/adolescentadultmeasures.pdf>
24. Updated Guidelines for Management of Cervical Cancer Screening Abnormalities, American College of Obstetrics and Gynecology (ACOG), accessed on April 19, 2021
<https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2020/10/updated-guidelines-for-management-of-cervical-cancer-screening-abnormalities>
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26. Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection (CDC), accessed July 24, 2017
<https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5709a1.htm>
27. Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People (UCSF Transgender Care), accessed on April 19, 2021
<https://transcare.ucsf.edu/guidelines>
28. Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized in the United States (CDC), accessed on April 19, 2021
https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html?CDC_AA_refVal=http%3A%2F%2Fwww.cdc.gov%2Fvaccines%2F%2F%2Finfo-by-product%2Fclinical-considerations.html
29. Interim Guidance for COVID-19 and Persons with HIV (DHHS)
<https://clinicalinfo.hiv.gov/en/guidelines/covid-19-and-persons-hiv-interim-guidance/covid-19-and-persons-hiv>

APPENDIX A
SAMPLE Sexual Health
Risk Assessment Form

Sexually transmitted diseases (STDs) raise the amount of HIV in the body and can make HIV easier to pass to another person. Alcohol and drugs can harm your immune system, stop HIV medication from working properly and increase side effects. To help your doctor help you stay healthy and lower your risk of passing HIV and STDs to others, please answer the following questions honestly. Your answers are entirely confidential.

1. Have you had sex (oral, vaginal, anal) within the **last 3 months**? Yes / No / Decline
 (If you answered No please skip to #6)
2. In the **last 3 months**, how many sexual partners did you have? # _____ Male / # _____ Female / # _____ Transgender
3. How often did you use condoms?
 Always (100%) / Most of the Time (75% or more) / Sometimes (50%) / Seldom (25%) / Never (0%)
4. In the **last 3 months** how many times have you had sex without using a condom?
 # _____ Oral / # _____ Vaginal / # _____ Anal; check one: Insertive (top) / Receptive (bottom) / Both
5. In the **last 3 months** what was the HIV status of your sex partner(s)? (Check all that apply)
 Positive / Negative / Unsure
6. Have you had any of the following symptoms in the **last 3 months**? **Yes** **No**

Discharge from penis/vagina	<input type="checkbox"/> <input type="checkbox"/>
Burning feeling with urination	<input type="checkbox"/> <input type="checkbox"/>
Sores on your genitals	<input type="checkbox"/> <input type="checkbox"/>
Anal discharge or pain	<input type="checkbox"/> <input type="checkbox"/>
Mucous or blood in your stool	<input type="checkbox"/> <input type="checkbox"/>
Throat sores or pain	<input type="checkbox"/> <input type="checkbox"/>
Skin rash	<input type="checkbox"/> <input type="checkbox"/>
7. Have you been diagnosed with a sexually transmitted disease (STD, such as Syphilis, Chlamydia, Gonorrhea, NGU, Genital Warts, and Genital Herpes) in the **last 3 months**? (Check one): Yes / No / Don't know
 If you answered yes, did you complete treatment? (Check one): Yes / No / Don't know
8. In the **last 3 months** have you used **non-injection** street drugs 9i.e. marijuana, meth, crystal, speed, glass, crack, ecstasy, cocaine)? Yes / No
9. Have you **ever injected** steroids, hormones, vitamins or street drugs? Yes / No
 a. If you answered yes, when was the last time you injected? _____
 b. Did you ever share needles? Yes / No
10. In the **last 3 months** do you feel that your alcohol or drug use caused you to engage in risky activities (i.e. unprotected sex, needle sharing), even once? Yes / No
11. Would you be interested in help to inform your sex and/ or needle sharing partner(s) of possible HIV exposure? Yes / No / Maybe

If you answered Yes or Maybe and would like to speak to a Counselor, please tell us the best way to contact you:

Phone: _____ Can we leave a confidential message? Yes / No

Text: _____ Email: _____

Provider/Staff Signature: _____

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