HUMAN IMMUNODEFICIENCY VIRUS (HIV) EDUCATION, COUNSELING, TESTING, AND REFERRAL SERVICES

I. General Information

These standards are based on the 2002 Centers for Disease Control (CDC) Sexually Transmitted Diseases Treatment Guidelines and the 2001 CDC Revised Guidelines for HIV Counseling, Testing, and Referral. These standards do not discuss HIV treatment or management but focus solely on HIV education, counseling, testing and referral

II. Personnel

[redacted] mid-level practitioners will conduct HIV counseling and testing with the assistance of HCAs. HCAs that have been trained may assist with education and testing when appropriate.
HIV counseling staff and medical staff **must** be knowledgeable about:

- Available counseling, testing and referral services within the affiliate.
- The impact of HIV on conditions being managed.
- Special considerations regarding confidentiality and consent for HIV positive patients.
- Providing care that is appropriate to the patient's culture, language, sex, gender orientation, age, and developmental level.

Training

Staff providing HIV counseling **must** be trained by licensed health professionals, health educators or experienced HIV counselors involved in HIV counseling and testing programs.

1. Training of HIV counselors **must** include the following information:

    - Transmission and prevention of HIV and natural history of HIV.
    - Assessment of risk for HIV infection.
    - Signs and symptoms associated with HIV infection and types of tests available.
    - Pros and cons of HIV testing and types of tests available.
    - An explanation of both confidential and anonymous testing, the differences, and the advantages/disadvantages of each.
    - Significance of HIV positive, negative, and indeterminate test results, as well as sensitivity and specificity of test used.
    - General prevention measures.
    - Negotiating risk reduction plans.
    - Community resources and appropriate referral agencies.
    - Basic reproductive health care management for HIV-positive women.
    - Affiliate practices to ensure the control of the spread of infection in the workplace.
    - Management of psychological emergencies.
    - Appropriate chart and records documentation.

2. Since HIV counseling and testing is incorporated into either preventive maintenance visits, STD visits, or other healthcare visits, supervision and evaluation of staff that provide this service will be conducted as a part of the overall CQI program. Either the Medical or CQI Director will conduct direct observation and/or chart review every other year or more often as needed.

FYI – Skills and characteristics of the HIV prevention counselor include:

1. Completion of standard training courses in patient-centered HIV prevention counseling or other risk-reduction counseling models
2. Belief that counseling can make a difference
3. Genuine interest in the counseling process
4. Active listening skills
5. Ability to use open-ended-rather than closed-ended questions
6. Ability to comfort with an interactive negotiating style rather than a persuasive approach
7. Ability to engender a supportive atmosphere and build trust with the patient
8. Interest in learning new counseling and skills-building techniques
9. Being informed regarding specific HIV transmission risks
10. Comfort in discussing specific HIV transmission risks
11. Comfort in discussing specific HIV risk behaviors (i.e., explicit sex or drug behaviors, including non-standard or uncommon risk behaviors)
12. Ability to remain focused on risk-reduction goals.
13. Support for routine, periodic, quality assurance measures.

Source: Revised Guidelines for HIV Counseling, Treatment and Referral available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5019a1.htm Accessed: 3/15/05.

III. Patient Selection

Patient Appointments:
Patients may incorporate their HIV testing in the preventive maintenance or other healthcare visits. If a patient calls and requests HIV testing they should be offered a general STD screening visit.

Practitioners will do the risk assessment, determine appropriate STD testing, and develop a risk reduction plan as necessary. HCAs that have had HIV training may assist in education and testing.

Patients at increased behavioral or clinical HIV risk will need more involved patient-centered counseling and risk reduction goal setting.

Patient History and Exam Forms:

For initial/annual visits, the initial/annual history form **must** be filled out, the sexual/behavior risk history reviewed, and a risk assessment determined. It is also important to review any history of serious medical illness and emotional problems or depression.

For non-initial/annual visits, an updated sexual/behavior risk history and risk assessment **must** be obtained. It is also important to review any history of serious medical illness and emotional problems or depression. The updated history and assessment **must** be documented in the chart.

Patient Recommendation for Testing:
HIV prevention counseling, testing, and referral is recommended for:

A. All patients in populations at increased behavioral or clinical HIV risk, (regardless of HIV prevalence)

B. Individual patients in settings with less than 1% HIV prevalence **(all Maine, New Hampshire, and Vermont health centers)** who:

- Have clinical signs or symptoms suggesting HIV infection (e.g. fever or illness of unknown origin, opportunistic infection [including active tuberculosis disease] without known reason for immune suppression).
- Have diagnoses suggesting increase risk for HIV infection (e.g., another STI or blood borne infection.).
- Self-report HIV risks
- **Specifically request an HIV test.**

C. All patients in settings with greater or equal to a 1% HIV prevalence.

D. Regardless of setting prevalence, behavioral or clinical risk which includes:

- All pregnant women
- All patients with possible acute occupational exposure, and
- All patients with known sexual or needle-sharing exposure to an HIV-infected person.

IV. Patient Education/Informed Consent

A. General information on HIV/AIDS can be provided using the PPNNE Protection from HIV/AIDS or another EMRC approved pamphlet.

B. Patients receiving HIV testing **must** read and be offered a copy of the Patient Information for Informed Consent – HIV Test.

C. All patients **must** read and sign the Request for Medical Services. If anonymous testing is offered, informed consent must still be obtained, but the consent itself **must** not contain the patient's name, signature, or other identification (the patient can sign with an "X").

V. Counseling, Testing and Referral Services

A. **HIV Preventive Counseling** – The primary goal of patient-centered counseling is risk reduction through personal goal setting. Patients at increased behavioral or clinical HIV risk will need more involved patient-centered counseling.

HIV prevention education and counseling on HIV/AIDS may be achieved by using a combination of written materials (Protection from HIV Fact Sheet), other audio-visual aids, and personal contact with a specially trained counselor.

A personalized risk assessment should be done to help the patient identify, understand and acknowledge at risk behaviors and situation.

Prevention **counseling must** include both basic and specific components of counseling.

1. The basic components or elements of prevention counseling provided to the patient are:

   - General information about HIV/AIDS.
   - HIV prevention strategies and a personalized risk assessment.
   - Explanation of confidential and anonymous services.

2. The specific components of **counseling** that **must** be available and offered if indicated are:

   - Information as to whether confidential or anonymous HIV serologic testing is offered by the affiliate, or that both are available.
   - Information about protection of confidentiality, including documentation of testing, authorized disclosures and antidiscrimination protection.
   - Explanation of HIV infection and AIDS, including the risk factors associated with infection.
   - Explanation of the benefits of early testing and treatment.
   - Explanation of tests offered and testing procedure.
   - Information on the HIV test and its benefits and consequences.
   - The accuracy of the HIV screening tests.
   - Implications of positive and negative results (including the 3-6 month window period) and the potential medical, social, and psychological implications.
   - HIV prevention information--general and particular to patient's current lifestyle or high risk factor(s), including contraceptive information as indicated.
   - The negotiation of a realistic and incremental plan for reducing risk.

- The date when results will be available and the method for obtaining results.
- The importance of obtaining test results and explicit procedure for doing so.
- The meaning of the test results in explicit, understandable language.
- Where to obtain further information or referral services, if the needed service is not offered at the affiliate.
- Advice on behavioral risk for HIV not to donate blood or semen and not to use the blood bank as a means of periodic HIV testing.
- 24-hour resource for crisis services, including identification of support systems during the waiting period.
- Suggestion to bring a support person of the **patient's** choice, at the time of receiving results.

B. **HIV Testing**

The following information **must** be given to the patient prior to HIV testing

- Patient Information for Informed Consent – HIV
- Information regarding the HIV test and its benefits and consequences.
- The importance of obtaining test results and explicit procedures for doing so.
- The meaning of the test results and test accuracy in explicit, understandable language.
- Where to obtain further information or, if applicable, HIV prevention counseling.
- Where to obtain other services, if needed

FYI – Elements of HIV Prevention Counseling Sessions

1. Keep the session focused on HIV risk reduction.
2. Include an in-depth, personalized risk assessment.
3. Acknowledge and provide support for positive steps already made.
4. Clarify critical rather than general misconceptions about HIV risk.
5. Negotiate a concrete, achievable behavior-change step that will reduce HIV risk.
6. Seek flexibility in the prevention approach and counseling process.
7. Provide skill-building opportunities. (i.e., have patients demonstrate how to put on a male condom).
8. Use explicit language when providing test results.
9. Ensure that the patient returns to the same counselor
10. Use a written protocol to help counselors conduct effective sessions.
11. Ensure ongoing support by supervisors and administrators.
12. Avoid using counseling sessions for data collection.
13. Avoid providing unnecessary information.

Taken from: CDC 2001 "Revised Guidelines for HIV Counseling, Testing and Referral" available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5019a1.htm Accessed: 3/15/05.

VI. Types of Testing and Logging of Test

HIV antibody testing is available by either blood testing or OraSure at all sites.

1. With **confidential testing**, the patient's unique identifier number **and** name must appear on the lab log. Only the unique identifier must appear on the laboratory request form, and the test tube label. Some state labs may also require name on both the laboratory request form and the test tube label. The patient must be given a copy of the same identifier. Charts of confidential patients will be filed with all other charts.

2. With **anonymous testing**, no record is kept of the patient's name. The unique identifier number must appear on the laboratory log, the laboratory request form, and the test tube label for each patient. This identifier must not contain the patient's actual name or chart number. The patient must be given a copy of the same identifier. Charts of anonymous patients need to be kept in a separate file.

VII. Providing Test Results

Results may be provided either in-person or by phone. At the testing visit, the practitioner or trained HCA **must** discuss with the patient the best and safest way for the patient to receive HIV test results, taking into account the patient's life circumstances. This must be clearly documented in the chart.

- Test results must be given to the patient only after the final written results are returned to the health care center.
- The patient must present a copy of the unique identifier if given at the time of initial testing.
- If test results are to be provided by phone;

1. Negative test results should be given in the context of the risk assessment, the window period, and risk reduction plan, and in such a way that confidentiality is guarded.

2. Positive test results **should not** be given over the phone or mailed to patients. It should be communicated that the test results are in and to make an appointment to obtain results. Exceptions **must** be carefully considered and **must** be documented in the patient medical record. An appointment **must** be available on the day the phone call is made.

    - The Director of Clinical Quality Improvement **must** be notified of all positive test results. She will help coordinate post-test education, counseling, and referral.
    - The patient must be advised that all positive screening tests were confirmed by the performance of a recognized secondary test such as the Western Blot, Immunofluorescent Assay (IFA), or other confirmatory tests.
    - If the patient wishes to have a sample taken again and sent for re-testing he or she **must** be scheduled or referred accordingly.

- The patient **must** be offered the option of further counseling or referrals as indicated, e.g., medical assessment and care.
- If a patient desires a written copy of the test result, it may be provided only within the context of confidential testing. A medical records release **must** be obtained.

FYI – Providing HIV Test Results by Telephone

Many clinicians routinely notify patients of negative test results for various diseases and conditions by means other than face-to face (e.g. by telephone). They also ask patients to return to discuss positive test results that might indicate potential life-threatening illnesses. This strategy can also be applied, under limited circumstances, to notifying patients of their HIV test results. Face-to-face provision of HIV test results is strongly encouraged for HIV-infected patients and HIV-uninfected patients at increased risk who might benefit from HIV prevention counseling and referral to medical, preventive, and support services. Providing uninfected patients who are not at increased risk the option of receiving HIV test results and counseling by telephone --- with the understanding that provider assurance of patient confidentiality is of paramount importance --- might be appropriate. Limited research indicates that offering patients the option of contacting the provider by telephone to receive negative HIV results might increase rates of receipt for results, satisfy patient preference for options, and preserve setting resources without apparent adverse consequences. Although no published research exists regarding use of telephones for providing positive HIV test results with most HIV test technologies, limited experience exists on using this method to provide HIV-positive results for home sample collection testing.

Source: Revised Guidelines for HIV Counseling, Treatment and Referral available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5019a1.htm Accessed: 3/15/05.

VIII. Counseling for Negative Test Results

1. Negative test results should be given in the context of the risk assessment, the window period, and risk reduction plan.

2. Post-test counseling and referral to prevention case management **must** be offered to individuals at clinical or behavioral high risk, including —

   - all pregnant women
   - patients with possible acute occupational exposure
   - patients with known sexual or needle-sharing exposure to an HIV-infected person
   - patients with known sexual exposure to an IV drug user
   - patients with clinical signs or symptoms suggesting HIV infection (e.g. fever or illness of unknown origin, opportunistic infection [including active tuberculosis disease] without known reason for immune suppression).
   - patients with diagnoses suggesting increase risk for HIV infection (e.g., another STI or blood borne infection).

3. Counseling of the above at-risk individuals should include —

   - prevention counseling as if not already provided pre-testing
   - interval(s) for follow up HIV test(s)

- information about and referral to services to support prevention behaviors
- medical services, as appropriate

4. **For individuals not at high risk as defined above —**

   - Test results may be provided without post-test counseling.
   - All the patients questions related to the test and result **must** be answered.
   - Additional post-test counseling **must** be available if requested by the patient.

5. See Referral and Resources Section for additional information.

FYI — Follow-Up Testing in Patients with Negative HIV Test Results

Single Possible or Known Exposure
Most infected persons will develop detectable HIV antibody within three months of exposure. If the initial negative HIV test was conducted within the first three months after exposure, repeat testing should be considered ≥3 months after the exposure occurred to account for the possibility of a false-negative result. If the follow-up test is nonreactive, the patient is likely not HIV-infected. However, if the patient was exposed to a known HIV-infected person or if provider or patient concern remains, a second repeat test might be considered ≥6 months from the exposure. Rare cases of seroconversion six to 12 months after known exposure have been reported. Extended follow-up testing beyond six months after exposure to account for possible delayed seroconversion is not generally recommended and should be based on clinical judgment and individual patient needs.

Ongoing Exposure
Persons with continued HIV risk behavior pose a special challenge for follow-up testing. In some settings, patients with ongoing risk represent a substantial proportion of those receiving HIV counseling, testing and referral. In most circumstances, follow-up HIV testing should be recommended periodically for patients with ongoing risk behavior. Follow-up testing would monitor the patient's HIV status, but also promote continued patient contact, opportunities for HIV prevention counseling and referral to additional preventive and support services.

No Identifiable Risk
In general, persons with no recent identifiable risk for HIV infection should receive additional HIV prevention counseling and follow-up testing when requested. Efforts should be made to understand why these patients repeatedly seek follow-up testing. These patients should be considered for in-depth prevention counseling and referral to support services, where appropriate.

Special Considerations
General recommendations for follow-up testing might not be applicable in all circumstances. In certain circumstances (e.g., when persons are simultaneously exposed to hepatitis C virus and HIV and when persons have received HIV vaccines), guidance should be provided only after consultation with specialists.

Source
Revised Guidelines for HIV Counseling, Treatment, and Referral available at www.cdc.gov/mmwr/preview/mmwrhtml/rr5019a1.htm Accessed: 3/15/05

IX. Counseling for Positive Test Results

1. Staff providing positive test results should ensure that the patient understands the test results and **must** ensure that all patient questions related to the test and result are answered.

2. Patients **must** be advised —

   - Of the opportunity for further post-test counseling either at the affiliate or via referral. The purpose of this visit is to assess whether the patient was able to obtain medical care, minimize transmission risk to partners and access other needed services.
   - That positive screening tests **must** be confirmed by an FDA approved confirmatory test such as the Western Blot, Immunofluorescent Assay (IFA).
   - About specific strategies to prevent transmission of HIV and other sexually transmitted or bloodborne infections. Supply or refer for safer sex equipment, condoms, contraception and emergency contraception if needed.
   - Of the importance of treatment and obtaining healthcare.
   - About medical and social support resources available. (See Referral and Resources for additional information.)
   - To refrain from donating blood, plasma, or organs.

3. Positive test results should not be given over the phone or mailed to patients. Exceptions **must** be carefully considered and **must** be documented in the patient medical record.
   Reference: MMWR, Vol 50, RR-19.

FYI — Providing Positive Test Results

- Give results promptly.
- Ensure that the patient understands the test result.
- Do not expect the patient to hear much of what is said after the result is given. Therefore, consider giving information in writing that the patient can read afterwards.
- Allow enough time to provide the patient with supportive counseling about feelings and responses to the result.
- Offer a follow up appointment to review test results and answer any questions
- Establish a plan of action on where the patient will go after he or she leaves the health center, who the patient will tell etc.
- Assist with or refer for immediate and long term needs.

Adapted from: Contraceptive Technology 18th edition, 2004 (table 7-4)

X. Charting of Test Results and Record Release of HIV Information

References to HIV risk assessment, counseling, education, recommendation for testing, and even that the patient was tested, may be incorporated into the chart and treated like any other medical information. However, some state law require that HIV test results, status, and/or referral for treatment must not be released unless the patient consents by signing the Authorization form.

For the sake of simplicity the following documentation system **must** be followed. This system will allow:

- Medical records of patients who test negative for HIV to be handled like all other medical information. (See specific guidelines below).
- For optimum patient care, medical records of patients who test positive for HIV will have information regarding their positive status incorporated into their chart. Therefore HIV positive patients **must** sign for authorization to release their medical records. (See specific guidelines below).

A. Negative HIV results

- Discussion of test results, whether in-person or by phone **must** be documented using the SOAP format on the "Other Notes" progress note. **However, the term 'STD bloodwork' must be used and not HIV.**
- The actual test results must be placed separately in the very back of the medical record behind a red sheet of paper. This is to assure that HIV lab results are not released unless the patient consents by signing the Authorization form.
- **Record release**; The same HIPAA Privacy rules apply to the patient charts except the actual test result **must not** be released with the chart (unless the patient requests it and signs the Authorization form).

B. Positive HIV results

- Discussion of test results, whether in-person or by phone **must** be documented using the SOAP format on the "Other Notes" progress note. **All references to HIV testing, counseling, test results, and/or referral, may be incorporated into the patient's medical records.**
- Positive test results may be noted on the patient's problem list.
- The actual test results must be placed separately in the very back of the medical record behind a red sheet of paper. This is to assure that HIV lab results are not released unless the patient consents by signing the Authorization form.
- **Record release;** Any release of information regarding HIV status is prohibited unless the patient has signed the Authorization to Release Healthcare Information and has given specific permission to release information relating to HIV test results, status, or treatment. If a patient wants his/her records released but refuses

to check permission to release HIV results or status, the Privacy Official must be consulted before records are released.

XI. Referral

1. Depending on the patient's needs and community resources, referrals should be offered for the following services, if not provided by the affiliate

   - prevention case management
   - medical evaluation, care, and treatment
   - partner counseling and referral services
   - reproductive health services
   - drug or alcohol prevention and treatment
   - mental health services
   - legal services
   - STI screening and care
   - screening and treatment for viral hepatitis
   - other services (e.g. assistance with housing, food, employment etc.)

2. Patients **must** be referred for care outside the affiliate if the patient's needs progress beyond affiliate management capability.

FYI — Providing Referrals

It is suggested that a referral to another provider include —
- name of the provider or agency
- range of services provided
- contact names and telephone and fax numbers, street addresses, e-mail addresses
- location/service area(s)
- hours of operation
- cost for services and acceptable methods of payment
- target population
- admission policies and procedures

It may also be helpful to include —
- competence in providing services appropriate to the patient's culture, language, sex, sexual orientation, age and developmental level
- eligibility
- application materials
- directions, transportation information, and accessibility to public transportation
- patient satisfaction with services

XII. Follow-up

Patients who test positive but don't return for their results will be managed in the same fashion as all other positive test results – 3 attempts to contact, at least 2 in writing unless the patient requests an alternative method of contact.

XIII. Post Exposure Prophylaxis (PEP)

A. **Occupational Exposure** – Occupational HIV exposure **must** be managed and treated as per OSHA and CDC guidelines. Refer to the Exposure/Needle-stick section of the Laboratory and Procedure Manual. The Director of Clinical Quality Improvement **must** be contacted.

B. **Non-occupational Exposure** – Non-occupational, sexual, or injection drug use or other non-occupational HIV exposure **must** be referred to an appropriate healthcare provider with necessary training and resources.

XIV. Reproductive Health Care of HIV Positive Patients

Women and men who are known to be HIV seropositive may be provided any reproductive health care service for which [redacted] has an approved program.

The patient **must** be told that:

- In addition to management of reproductive tract manifestations of HIV disease, routine services are offered;
- Primary care for non-reproductive manifestations of HIV infection may be obtained by referral elsewhere, preferably by a health care provider experienced in care for HIV-positive individuals;
- Referrals for continuing care will be given if conditions progress beyond [redacted] management capacity.

In order to provide appropriate reproductive and general health care that is specific to the needs of HIV positive patients, the patient's HIV positive status needs to be documented in the patient's medical chart. The patient will be advised that the chart contains such information and that the usual measures to ensure patient confidentiality will be in place.

The patient must sign the Authorization to Release Medical Information before the release of their medical records regarding HIV status and treatment.

Reproductive health care management of HIV positive patients includes, but is not necessarily limited to these recommendations:

1. Condyloma Accuminata

   Spontaneous regression of lesions is not common, and recurrence after treatment is more pronounced in HIV positive individuals. Advise treated patients to use tub soaks or warm compresses frequently to hasten healing, and remind the patient that treatments causing open wounds may increase transmissibility of HIV.

   If not recently performed, advise serologic testing for syphilis.

2. Cervical Neoplasia in Women

Medical studies suggest a more fulminant course of cervical neoplasia and a higher rate of false-negative cytologic results among HIV seropositive women. Therefore, it is prudent to pursue screening for cervical neoplasia and management of abnormalities relatively more aggressively.

a. Pap smear testing should be repeated every 6-12 months.

b. Colposcopic evaluation must be performed in the presence of any low grade lesion on Pap smear (including ASCUS or AGCUS; koilocytosis/ HPV, or LGSIL), as observation alone in this situation in not adequate.

3. Other Genital and Anal Intraepithelial Neoplasia

Women with iatrogenic immunosuppression have been shown to have an incidence of vulvar cancer 100 times that of age-matched controls. It is reasonable to proceed as though HIV-infected women also show a higher incidence of vulvar, vaginal and anal intraepithelial neoplasia because of their immunosuppression and their high risk for having been exposed to HPV.

Women with undiagnosed, suspicious and/or persistent lesions of the vulva, vagina or anus must be promptly evaluated or referred.

Men with undiagnosed, suspicious and/or persistent lesions of the genitalia, perineum or anus must be promptly evaluated or referred.

4. Genital Ulcerative Diseases

a. Immunocompromised patients may have prolonged or severe episodes of genital, perianal, or oral herpes. Lesions caused by HSV are common among HIV-infected patients and may be severe, painful, and atypical. Episodic or suppressive therapy with oral antiviral agents is often beneficial.

Recommended Regimens for Episodic Infection in Persons Infected with HIV

Acyclovir 400 mg orally three times a day for 5--10 days,
OR
Acyclovir 200 mg five times a day for 5--10 days,
OR
Famciclovir 500 mg orally twice a day for 5--10 days,
OR
Valacyclovir 1.0 g orally twice a day for 5--10 days.

Recommended Regimens for Daily Suppressive Therapy in Persons Infected with HIV

Acyclovir 400--800 mg orally twice to three times a day,
OR
Famciclovir 500 mg orally twice a day,
OR
Valacyclovir 500 mg orally twice a day.

In the doses recommended for treatment of genital herpes, acyclovir, valacyclovir, and famciclovir are safe for use in immunocompromised patients. For severe cases, initiating therapy with acyclovir 5-10 mg/kg body weight IV every 8 hours may be necessary.

If lesions persist or recur in a patient receiving antiviral treatment, HSV resistance should be suspected and a viral isolate obtained for sensitivity testing. Such patients should be managed in consultation with a specialist, and alternate therapy should be administered.

b. Syphilis: Among people with HIV disease, there is an increased likelihood of rapid progression to neurosyphilis and the persistence of syphilis despite standard therapy. Careful surveillance of titters following treatment is essential.

c. HIV ulcers: Ulcerative lesions negative for herpes, syphilis and chancroid and unresponsive to treatment for same have been reported by several observers. Their lesions were responsive to zidovudine. This should be kept in mind when unable to diagnosis specifically and/or treat a persistent ulcerative lesion. Refer for further expert evaluation and treatment.

5. Vulvovaginal Candidiasis

a. Start with standard treatment regimens of topical therapy, but if patient is unresponsive, try variations tailored to patient's symptoms (e.g., one application per day for 5 days before every menses, or one application daily or every other day). Make sure the patient has an ample supply of medication so she can begin treatment when initial symptoms appear.

b. For infections unresponsive to topical treatment and for recurrent infections, oral systemic therapy may include:

- Ketoconazole, 400 mg once a day for 14 days, then 5 days a month for 6 months or indefinitely. Obtain baseline liver

function tests (LFTs), then repeat at 2 weeks, at 3 months, and then at 6 month intervals. Ketoconazole is contraindicated in persons with active liver disease or taking Rifampin or other medications with liver toxicity.

- Fluconazole, 100 - 200 mg orally once a day for 14 days, should be used for patients with active liver disease or taking other hepatotoxic drugs.
- Fluconazole 200 mg orally once a week may be used for chronic suppressive therapy.

6. Contraception

Contraception must be addressed with each patient to ascertain individual needs. Studies have shown that HIV infection may not of itself increase a patient's ability or desire to contracept; therefore, careful attention needs to be given to the patient's lifestyle preference. Clinicians should not make the assumption that HIV infection will change the patient's skills or desire in this area.

Note that patients must be offered the full range of birth control methods with considerations of limitations discussed below. Surgical sterilization should be neither denied nor encouraged.

HIV infection is a special consideration in the use of an intrauterine device (IUD) and AIDS is an absolute contraindication. When a non-barrier method of contraception is chosen, emphasis must be given to the fact that these methods offer no protection against the transmission of HIV. Patients must be counseled regarding the need for concurrent use of a barrier method, both for the prevention of HIV transmission to others and to protect against the infection with or transmission of other STIs.

7. Pregnancy

Once identified as being HIV-infected, pregnant women should be informed specifically about the risk for perinatal infection. Current evidence indicates that, in the absence of antiretroviral and other interventions, 15%--25% of infants born to HIV-infected mothers will become infected with HIV; such evidence also indicates that an additional 12%--14% are infected during breastfeeding in resource-limited settings where HIV-infected women breastfeed their infants into the second year of life. However, the risk of HIV transmission can be reduced substantially to $\leq$2% through antiretroviral regimens and obstetrical interventions (i.e., AZT or nevirapine and elective c-section at 38 weeks of pregnancy) and by avoiding breastfeeding. Pregnant women who are HIV-infected should be counseled about their options (either on-site or by referral), given appropriate antenatal treatment, and advised not to breastfeed their infants (for women living in the United States, where infant formula is readily available and can be safely prepared). (MMWR STD Treatment Guidelines 2002)

XV. Tuberculosis Testing for Certain High Risk Persons

The tuberculin skin test is a screening test. The purpose of the test is to evaluate whether or not a person may have been exposed to tuberculosis. A positive skin reaction does not necessarily indicate active tuberculin disease. Persons who are immunocompromised, including patients with HIV are more likely to have an impaired response to the tuberculin skin test leading to a false negative test result. See Immunization in Section 1 of the Medical Protocol for specifics of TB testing.

XVI. Resources for HIV/AIDS

General HIV/AIDS Information	CDC National Center for HIV, STD, and TB Prevention	www.cdc.gov/nchstp/od/nchstp.html Accessed: 3/15/05
	CDC National AIDS Hotline in English or Spanish	(800) 342-2437
	CDC National AIDS Hotline TTY	(800) 243-7889
	CDC National STD Hotline	(800) 227-8922
	CDC National Prevention Information Network	www.cdcnpin.org Accessed: 3/15/05 or (800) 458-5231 (in English and Spanish)
	"CDC Revised Guidelines for HIV Counseling, Testing and Referral" MMWR. November 2001:50(RR-19);1-58	www.cdc.gov/mmwr/preview/mmwrhtml/rr5019a1.htm Accessed: 3/15/05
Post Occupational Exposure Prophylasis	National Clinicians' Post-Exposure Prophylaxis Hotline	www.ucsf.edu/hivcntr/ Accessed: 3/15/05 or (888) 448-4911
	"Antiretroviral Postexposure Prophylaxis After Sexual, Injection-Drug Use, or Other Nonoccupational Exposure to HIV in the United States" MMWR January 2005;54(RR02);1-20.	www.cdc.gov/mmwr/preview/mmwrhtml/rr5402a1.htm Accessed: 3/15/05
Testing	Counseling Protocols	www.cdc.gov/hiv/projects/respect-2/counseling.htm Accessed: 3/15/05
	CLIA — Clinical Laboratory Improvement Amendments of 1988	www.cms.hhs.gov/clia Accessed: 3/15/05
	CDC Guidelines on HIV testing	www.cdc.gov/hiv/testing.htm Accessed: 3/15/05
	Ora-Quick Rapid HIV-1 Antibody Test	www.orasure.com Accessed: 3/15/05 or OraSure, 150 Webster St., Bethlahem, PA 18015 800-ORASURE (672-7873)
Treatment	HIV/AIDS Treatment Information Service	http://aidsinfo.nih.gov/ Accessed: 3/15/05 or (800) 448-0440 (In English and Spanish)
	AIDS Clinical Trials Information Service	