# 22 HIV/AIDS

## 22.1 *MANDATORY MANAGED CARE ENROLLMENT IN NEW YORK CITY EXPANDS TO INCLUDE MEDICAID BENEFICIARIES WITH HIV/AIDS*

Mandatory Managed Care enrollment of people with HIV/AIDS is now in effect in New York City. While there are still some exclusions, such as homelessness or chronic illness, most persons with HIV/AIDS who were previously exempt from mandatory enrollment into a Medicaid Managed Care plan will no longer be exempt. Please note that persons that live in Single Room Occupancy (SRO) do not qualify as homeless and are therefore not exempt. Implementation of mandatory care enrollment is being phased in gradually throughout the five boroughs of New York City.

All Medicaid eligible persons will be notified by mail and receive a *Consumer's Guide to Medicaid Managed Care in New York City,* mandatory notice letter as well as specific information on how to choose a health plan.

**Enrollment**

Individuals with HIV/AIDS have the option to choose either a Medicaid Managed Care plan or one of the three HIV SNPs (Special Needs Plan). Non-SSI beneficiaries with HIV/AIDS will have sixty (60) days to choose a plan, but may request an additional thirty (30) days to make a choice. SSI beneficiaries will be given ninety (90) days to choose a managed care plan. People who want to choose a plan should call New York Medicaid CHOICE at 1-800-505-5678. Persons with HIV/AIDS who do not select a plan voluntarily will be automatically enrolled into a Medicaid Managed Care plan, such as NHP. They will not be assigned to a SNP. Persons with HIV/AIDS can change plans at any time, but if they change to a SNP, they can not come back to a Medicaid Managed Care plan.

**How will Primary Care Physicians be impacted?**

Persons with HIV/AIDS who are enrolled in NHP could be assigned to your primary care practice. There are some benefits that are covered by Medicaid FFS for members with HIV that are not covered by the plan, such as certain HIV related lab tests, Cobra case management and AIDS adult day heath care (ADHC). NHP maintains a network of providers with expertise in HIV/AIDS primary and specialty care, many of whom are located in Designated AIDS Centers. You can search the Provider Directory at www.getnhp.com to find these providers. As with all other in–network specialty consultations, a NHP referral form is not required.

**HIV Standards of Care**

For NHP to meet the needs of our members with HIV/AIDS, we must ensure that our physicians utilize HIV treatment standards and care coordination requirements. To learn more about the HIV clinical guidelines go to http://www.hivguidelines.org/.

**Case Management**

NHP attempts to enroll all of our members with HIV/AIDS into our Case Management program. To refer a patient with HIV/AIDS into Case Management, call 1-800-765-3805 (NHP) or 1-800-250-5007 (SHP).

To find out more about mandatory HIV enrollment, go to:
http://www.nyhealth.gov/health_care/managed_care/living_with_hiv/.

## 22.2 *HUMAN IMMUNODEFICIENCY VIRUS*

The Plan has an obligation to inform its MMC members newly diagnosed with HIV infection or AIDS, and are known to the Plan, of their enrollment options including to disenroll from the Plan's MMC product and to enroll into HIV Special Needs Plans (SNP), if such plan is available.

HIV Specialists and Primary Care clinicians should be capable of evaluating HIV-infected patients at all stages of HIV infection. Primary care clinicians should consult with an HIV Specialist when initiating or changing treatment.

Providers should:

- Screen all pregnant members and conduct ongoing risk assessments for both maternal and fetal risk at subsequent prenatal follow-up visits for all pregnant women, as per NYS prenatal care standards.
    - Risk assessments include genetic, nutritional, psychosocial, historical and emergency obstetrical, medical-surgical risk factors, and HIV counseling and testing.
    - Psychosocial assessments include economic, social, psychological and emotional problems as well as past domestic violence or sexual assault.
- Develop and/or coordinate programs of nutrition screening and counseling as required by NYSDOH regulations.
- Provide HIV pretest counseling with the clinical recommendation of testing at the initial visit with repeat HIV test in the third trimester (34-36 weeks) to all pregnant women
- Informed Consent for HIV Testing has been simplified; it can now be part of a general consent for treatment. When the HIV testing consent is merged into the general consent, specific opt out language for HIV testing must be included.

- Persons being asked to consent to HIV testing must be provided the following explanations:

  - ✓ HIV is the virus that causes AIDS and can be transmitted through: unprotected sex (vaginal, anal, or oral sex) with someone who has HIV; contact with blood as in sharing needles (piercing, tattooing, drug equipment including needles); by HIV-infected pregnant women to their infants during pregnancy or delivery; or while breast feeding.
  - ✓ There are treatments for HIV/AIDS that can help an individual stay healthy.
  - ✓ Individuals with HIV/AIDS can adopt safe practices to protect uninfected persons from acquiring HIV and infected people from acquiring additional strains of HIV.
  - ✓ Testing is voluntary and can be done anonymously at a public testing center.
  - ✓ The law protects the confidentiality of HIV test results and other related information.
  - ✓ The law prohibits discrimination based on an individual's HIV status and services are available to help with such consequences.
  - ✓ Consent for HIV related testing remains in effect until it is withdrawn verbally or in writing. If the consent was given for a specific period of time, it remains in effect for that time period only. In any case, persons may withdraw their consent at any time.
- This information may be provided by the person ordering the test or through his representative (the representative can be a medical or non-medical person) through oral, written or electronic mechanisms with no formal pre-test counseling required. For adults not able to consent for themselves, the Family Health Care Decisions Act stipulates who is able to consent for care in a variety of circumstances.

Those women and their newborns must have access to services for the positive management of HIV disease, psychosocial support and case management for medical, social and addictive services. Call Plan's Care Coordination Department for case management services.

## 22.3 *SEXUALLY TRANSMITTED DISEASE (STD) SERVICES*

The Plan asks that all providers assure timely and accurate required reporting of sexually transmitted diseases (STD). If your office provides STD screening, diagnosis and treatment, please do so in a manner consistent with the New York City Department of Health and Mental Hygiene protocols. Inform members that confidential STD services are available through the New York City Department of Health and Mental

Hygiene for non-enrolled sexual and needle sharing partners at no charge. Use screening protocols based on New York City Department of Health and Mental Hygiene recommendations for asymptomatic patients seen for prenatal, family planning, and emergency services and for high-risk patients. Screen and treat Plan members in a manner consistent with requirements for high priority STDs and STD outbreaks. Use New York State Department of Health or equivalent STD treatment guidelines. Assure that known contacts are appropriately advised. Use New York City Department of Health and Mental Hygiene approved protocols for evaluation of sexual and needle-sharing partners of STD infected members. Provide STD related health education and risk reduction information to members. Links to NYCDOHMH recommended protocols, treatment guidelines and information are as follow,

Screening Guidelines: http://www.nyc.gov/html/doh/downloads/pdf/std/sti-screening-guidelines.pdf

STD Treatment Guidelines: http://www.nyc.gov/html/doh/downloads/pdf/std/std-treatment-guideline-2006.pdf or at http://www.cdc.gov/std/treatment/2006/toc.htm

STD Summary Treatment Guideline: http://www.nyc.gov/html/doh/downloads/pdf/std/sti-summary-treatment-guidelines-card.pdf

STD Health Education and Risk Reduction Information: http://effectiveinterventions.org/

Recommendations of the 1996 U.S. Preventive Services Task Force concerning screening for STDs can be found at the web site http://www.ahrq.gov/clinic/. This web site provides the latest available recommendations on preventive intervention, screening tests, counseling, immunizations and chemoprophylactic regimes for more than 80 conditions including Chlamydial infection, genital herpes simplex, Gonorrhea, HIV and Syphilis.

## 22.4 *SUBJECT: CARING FOR ADULTS AND CHILDREN WITH HIV/AIDS*

As part of its Quality Assessment Performance Improvement program, the Plan adopted guidelines to assist all its providers in the management and treatment of HIV positive members and members with AIDS. These treatment guidelines are the AIDS Institute of the New York State Department of Health's, in collaboration with the John Hopkins University Division of Infectious Diseases, most current publications of:

- Post-Exposure Prophylaxis
- Adults
- Adolescents
- Pediatrics
- Women's Health
- HIV Prevention

- HIV and Mental Health
- HIV and Substance Use
- HIV and Oral Health
- HIV and Pharmacy
- Perinatal Transmission
- The Clinical Guidelines Program

We have included the guideline Primary Care Approach to HIV – Infected Patient as part of this section (see section 22.9); for other guidelines just go to www.hivguidelines.org

## 22.5 *MEMBER EDUCATION AND PREVENTION MATERIALS*

Providers should have sufficient HIV Education and Prevention materials in their office waiting rooms that address:

- How HIV is spread
- High risk behaviors and risk-reduction strategies
- Testing options: rapid vs. conventional, anonymous vs. confidential.
- What test results mean with explanation of the "window period"
- The confidentiality of getting tested, test results, case reporting, and partner notification.

The New York State Department of Health's website offers Providers materials that will help them educate their patients regarding HIV & AIDS, such as:

**I. *Brochures, Booklets & Posters***

- Ordering Information & On-Line Orders
- HIV/AIDS Transmission, Prevention & Awareness
- HIV & Sexually Transmitted Diseases (STDs)
- HIV Counseling & Testing
- Expanded Syringe Access Program
- HIV Prevention & Injection Drug Use
- Hepatitis

- Pregnancy
- HIV Reporting & Partner Notification
- HIV Medications & Treatment Adherence
- ADAP Plus
- Living with HIV/AIDS
- How To Gain Access To County Jails For Delivery Of HIV/AIDS Services

## II. *HIV/AIDS Transmission, Prevention & Awareness*

- **General Adult Audiences**
  - Instructions for Using a Male Condom (PDF, 88KB, 4pg.)
  - Could It Be Acute HIV? - Booklet, September 2007 (PDF, 444KB, 8pg.)
  - Could It Be Acute HIV? - Booklet, October 2007 (Spanish) (PDF, 276KB, 8pg.)
  - 100 Questions and Answers about HIV/AIDS - Booklet, February 2008 (PDF, 1MB, 52pg.)
  - 100 Questions and Answers about HIV/AIDS (Spanish) - Booklet, February 2008 (PDF, 634KB, 52pg.)
  - HIV and AIDS Facts - Brochure, November 2004 (English) (PDF, 1.8MB, 12pg.)
  - HIV and AIDS Facts - Brochure, November 2004 (Spanish) (PDF, 289KB, 12pg.)
  - What can I do if I have just been exposed to HIV? - Brochure, February 2006 (English) (PDF, 42KB, 2pg.)
- **Deaf and Hard of Hearing**
  - HIV/AIDS: Basic Facts for the Deaf and Hard of Hearing (PDF, 376KB, 2pg.)
- **Native Americans**
  - Protect Our Nations from HIV and AIDS - Brochure, March 2004 (PDF, 1.5MB, 2pg.)

- **Older Adults**
  - Age Won't Protect You From AIDS - Poster (Female) (PDF, 79KB, 1pg.)
  - Age Won't Protect You From AIDS - Poster (Female) (PDF, 78KB, 1pg.)
  - Age Won't Protect You From AIDS - Poster (Female) (Spanish) (PDF, 819KB, 1pg.)
  - Age Won't Protect You From AIDS - Poster (Male) (PDF, 75KB, 1pg.)
  - Age is no Barrier - Brochure, Rev. Sept. 2004 (English) (PDF, 5.5MB, 2pg.)
  - Age is no Barrier - Brochure, Rev. Dec. 2004 (Spanish) (PDF, 90KB, 2pg.)

- **Women**
  - What's Your Pleasure? How to Use the Female Condom - Booklet (PDF, 647KB, 4pg.)
  - What's Your Pleasure? How to Use the Female Condom - Booklet (Spanish) (PDF, 969KB, 2pg.)
  - What's Your Pleasure? How to Use the Female Condom - Poster (PDF, 924KB, 1pg.)
  - What's Your Pleasure? How to Use the Female Condom - Poster (Spanish) (PDF, 1.2MB, 1pg.)

  - They've been hit. With AIDS, too - Poster (English) (PDF, 129KB, 1pg.)
  - They've been hit. With AIDS, too - Poster (Spanish) (PDF 151KB, 1pg.)
  - And we shall win! African American women and HIV (PDF, 200KB, 1pg.)
  - To Love is to Protect (English - Racially/Ethnically diverse group) (PDF, 96KB, 1pg.)
  - To Love is to Protect (English - African-American woman) (PDF, 70KB, 1pg.)
  - For You, For Me, For Us (Eng/Span) (PDF, 145KB, 1pg.)
  - Respect Yourself, Protect Yourself (English) (PDF, 153KB, 1pg.)
  - En el estado de Nueva York, las mujeres hispanas represetan... (PDF, 93KB, 1pg.)

- **Educators, Parents, Caregivers and Youth**
  - Talking with Young People About HIV and AIDS- Booklet (English) (PDF, 827KB, 20pg.)
  - Talking with Young People About HIV and AIDS - Booklet (Spanish) (PDF, 1.4MB, 20pg.)
  - Everybody's Not Doin' It - Poster (English) (PDF, 878KB, 1pg.)
  - The Super Sleuths Learn About HIV and AIDS (English) (PDF, 4.7MB, 13pg.)
  - The Super Sleuths Learn About HIV and AIDS (Spanish) (PDF, 3MB, 13pg.)
  - Animals to the Rescue: Teaching Kids about HIV (English) (PDF, 4MB, 12 pg.)
  - Animals to the Rescue: Teaching Kids about HIV (Spanish) (PDF, 4MB, 12 pg.)

- **HIV & Sexually Transmitted Diseases (STDs)**
  - STD & HIV Facts - Brochure, September 2007 (English) (PDF, 1MB, 2pg.)
  - STD & HIV Facts - Brochure, December 2006 (Spanish) (PDF, 1MB, 2pg.)
  - What you Need to Know about the Links between HIV and STDs - Brochure, Rev. Nov. 2004 (English) (PDF, 375KB, 2pg.)
  - What you Need to Know about the Links between HIV and STDs - Brochure, Rev. Nov. 2004 (Spanish) (PDF, 402KB, 2pg.)
  - Diseases that can be Spread During Sex - Brochure, Rev. 7/08 (PDF, 406KB, 11pg.)
  - Diseases that can be Spread During Sex - Brochure, Rev. 7/08 (Spanish) (PDF, 484KB, 11pg.)

- **HIV Counseling & Testing**
  - Information for Defendants in Sexual Assault Cases (PDF, 61KB, 2pg.)
  - Information for Defendants in Sexual Assault Cases- Spanish (PDF, 72KB, 2pg.)
  - Information for Survivors of Sexual Assault (PDF, 371KB,2pg.)

- Information for Survivors of Sexual Assault - Spanish (PDF, 405KB, 3pg.)
- Thinking About HIV?: HIV Testing - Poster, June 2005 (English) (PDF, 491KB, 1pg.)
- Estás pensando en el VIH? - Poster, June 2005 (Spanish) (PDF, 190KB, 1pg.)
- Find Out Now: HIV Rapid Testing - Poster, June 2005 (English) (PDF, 475KB, 1pg.)
- Averígualo Ahora: Recibe Tus Resultados Hoy - Poster, June 2005 (Spanish) (PDF, 194KB, 1pg.)
- Good Reasons to Get an HIV Test - Brochure, Revised October 2005 (English)(PDF, 4MB, 2pg.)
- Good Reasons to Get an HIV Test - Brochure, Rev. October 2005 (Spanish) (PDF, 169KB, 2pg.)
- Two Good Reasons to Get an HIV Test - Poster (English- Caucasian Male/Female Couple) (PDF, 137KB, 1pg.)
- Two Good Reasons to Get an HIV Test - Poster (English - African-American Male/Female Couple) (PDF, 131KB, 1pg.)
- Two Good Reasons to Get an HIV Test - Poster (English - Caucasian/African-American Male/Male Couple) (PDF, 129KB, 1pg.)
- Two Good Reasons to Get an HIV Test - Poster (English - Asian/Pacific Islander Male/Female Couple) (PDF, 104KB, 1pg.)
- Two Good Reasons to Get an HIV Test - Poster (Spanish - Caucasian/African-American Male/Male Couple) (PDF, 133KB, 1pg.)
- Two Good Reasons to Get an HIV Test - Poster (Spanish - Caucasian Male/Female Couple) (PDF, 139KB, 1pg.)

- **What's Your Status? Testing videos and DVD now available**

  The New York State Department of Health AIDS Institute is pleased to announce availability of "What's Your Status?" an audiovisual resource promoting HIV testing.

  "What's Your Status?" is available in three formats: English VHS, VHS loop with both English and Spanish, and a DVD with both English and Spanish. The resource was adapted with permission from the New York City

Department of Health and Mental Hygiene to promote HIV testing. It covers the following content and testing scenarios:

- Anonymous HIV testing
- Who's at risk and should be tested
- Window period
- Prevention and risk reduction
- Persons receiving negative test results
- Persons receiving positive test results
- Prevention of perinatal transmission

To request a free copy, send an e-mail to: HIVPUBS@health.state.ny.us

Please be sure to indicate which of the following versions you request using both publication # and title:

#9528 - What's Your Status? VHS, English only

#9529 - What's Your Status? VHS, English and Spanish

#9530 - What's Your Status? DVD, English and Spanish

Please note that due to quantities, requests are limited to one copy per publication #, per customer.

- **Expanded Syringe Access Program**
  - Expanded Syringe Access Program (ESAP) Safety Insert - Brochure, January 2008 (English) (PDF, 583KB, 2pg.)
  - How to Safely Dispose of Household Sharps - Brochure, December 2007 (English) (PDF, 321KB, 2pg.)
  - How to Safely Dispose of Household Sharps - Brochure, December 2007 (Spanish) (PDF, 332KB, 2pg.)
  - Be Aware Don't Share - Wallet Card, October 2007 (English) (PDF, 234KB, 2pg.)
  - Be Aware Don't Share - Wallet Card, Revised January 2006 (Spanish) (PDF, 12KB, 2pg.)

- How do you control your diabetes? Don't panic: ESAP can help! - Brochure, October 2007 (English) (PDF, 184KB, 2pg.)
- How do you control your diabetes? Don't panic: ESAP can help! - Brochure, May 2003 (Spanish) (PDF, 93KB, 2pg.)
- How do you control your diabetes? Don't panic: ESAP can help! - Brochure, January 2003 (Chinese) (PDF, 1.5MB, 2pg.)

- **HIV Prevention & Injection Drug Use**
  - Buprenorphine: A New Drug for Treating Heroin Addiction - April 2007 (English) (PDF, 49KB, 4pg.)
  - Buprenorphine: A New Drug for Treating Heroin Addiction - April 2007 (Spanish) (PDF, 63KB, 4pg.)
  - Ever Wish You Could...Quit using heroin? Protect yourself from HIV infection? Get healthier? - Booklet, March 2006 (English) (PDF, 657KB, 7pg.)
  - Ever Wish You Could...Quit using heroin? Protect yourself from HIV infection? Get healthier? - Booklet, March 2006 (Spanish) (PDF, 9MB, 12pg.)
  - Stay Healthy and Survive - Flier, July 2006 (English) (PDF, 96KB, 2pg.)
  - Stay Healthy and Survive - Flier, March 2003 (Spanish) (PDF, 491KB, 2pg.)

- **Hepatitis**
  - What Do You Know About Hepatitis C and HIV? - Brochure, Rev. March 2008 (English) (PDF, 977KB, 2pg.)
  - What Do You Know About Hepatitis C and HIV? - Brochure, Rev. March 2008 (Spanish) (PDF, 1MB, 2pg.)
  - Prevent Hepatitis A - Brochure, January 2006 (English) (PDF, 547 KB, 2pg.)
  - What you Need to Know about Hepatitis C: A Guide for People with HIV Infection - Booklet, October 2005 (English) (PDF, 898KB, 12pg.)
  - What you Need to Know about Hepatitis C: A Guide for People with HIV Infection - Booklet, April 2002 (Spanish) (PDF 1.2MB, 13pg.)

- **Pregnancy**
  - Important News for Pregnant Women - Revised January 2006 (English) (PDF, 274KB, 2pg.)
  - Important News for Pregnant Women - Revised January 2006 (Spanish) (PDF, 100KB, 2pg.)
  - Pregnancy & HIV: Caring for yourself and your baby - Brochure, December 2004 (English) (PDF 218KB, 2pg.)
  - Pregnancy & HIV: Caring for yourself and your baby - Brochure, March 2005 (Spanish) (PDF, 140KB, 2pg.)
  - Important News For New Mothers About Your Baby's HIV Test, December 2004
    - English (PDF, 100KB, 2pg.)
    - Spanish (PDF, 31KB, 2pg.)
    - Chinese (PDF, 1.2MB, 2pg.)
    - Creole (PDF, 32KB, 2pg.)
    - French (PDF, 34KB, 2pg.)
    - Vietnamese (PDF, 4MB, 2pg.)
  - Breast is Best Unless You Have HIV (English) (PDF, 147KB, 1pg.)
  - Breast is Best Unless You Have HIV (Spanish) (PDF, 146KB, 1pg.)

- **HIV Reporting & Partner Notification**
  - There's Something I Need to Tell You...A step-by-step guide to telling your partners that they may have HIV - Booklet, November 2003 (English) (PDF, 170KB, 23pg.)
  - There's Something I Need to Tell You...A step-by-step guide to telling your partners that they may have HIV - Booklet, January 2004 (Spanish) (PDF, 156KB, 23pg.)
  - Partner Notification: We can work together to stop the spread of HIV - Brochures, July 2004
    - English (PDF, 1.7MB, 2pg.)
    - Spanish (PDF, 1.5MB, 2pg.)
    - Chinese (PDF, 554KB, 2pg.)
    - French (PDF, 191KB, 2pg.)

        - Khmer (PDF, 2.3MB, 2pg.)
        - Laotian (PDF, 949KB, 2pg.)
        - Polish (PDF, 1.9MB, 2pg.)
        - Russian (PDF, 1.2MB, 2pg.)
        - Vietnamese (PDF, 1.7MB, 2pg.)
    - Thinking About Telling: The PartNer Assistance Program - Photonovella, November 2002 (Spanish) (PDF, 2.44MB, 16pg.)

- **Medications & Treatment Adherence**
    - Staying on Schedule: Tips for Taking your HIV Medicines - Brochure, October 2007 (PDF, 671 KB,12pg.)
    - Staying on Schedule: Tips for Taking your HIV Medicines - Brochure, November 2007 (Spanish) (PDF, 1.1 MB, 10pg.)
    - Staying on Schedule: How To Take Each HIV Medicine - Booklet, December 2007 (PDF, 1.4MB, 22pg.)
    - Staying on Schedule: How To Take Each HIV Medicine - Booklet, April 2008 (Spanish) (PDF, 1.2 MB, 22pg.)
    - Stay on Schedule: Tips for Remembering your Medication - Wallet card, June 2001 (English) (PDF, 107KB, 4pg.)
    - Stay on Schedule: Tips for Remembering your Medication - Wallet card, April 2002 (Spanish) (PDF, 123KB, 4pg.)
    - Managing Side Effects of HIV Medications (PDF, 565KB, 36pg.)
    - Managing Side Effects of HIV Medications (Spanish) (PDF, 760KB, 19pg.)

- **Leadership Training Institute**
    - We're Making a Difference: PWA/LTI - Brochure, (English) (PDF, 366KB, 2pg.)
    - We're Making a Difference: PWA/LTI - Brochure, (Spanish) (PDF, 132KB, 2pg.)
    - We're Making a Difference: PWA/LTI - Poster (English) (PDF, 190KB, 1pg.)
    - We're Making a Difference: PWA/LTI - Poster (Spanish) (PDF 190KB, 1pg.)

- **ADAP Plus**
  - ADAP Plus - Brochure, September 2001 (English) (PDF, 736KB, 2pg.)
  - ADAP Plus - Brochure, September 2001 (Spanish) (PDF, 862KB, 2pg.)
  - ADAP Plus - Brochure, September (French) (PDF, 887KB, 2pg.)

- **Living with HIV/AIDS**
  - Alcohol & HIV: A Mix You Can Avoid - Booklet, August 2009 (PDF, 760KB, 10pg.)
  - Staying Healthy for Life - A Resource Guide for People with HIV (PDF, 831 KB, 16pg.)
  - Patient Resources Directory
  - Staying Healthy for Life - A Resource Guide for People with HIV (Spanish) (PDF, 1.2 MB, 16pg.)
  - HIV and Smoking: Smoking Stresses Your Immune System - Poster, June 2007 (English) (PDF, 718KB, 1pg.)
  - HIV and Smoking: Smoking Stresses Your Immune System - Poster, June 2007 (Spanish) (PDF, 92KB, 1pg.)
  - Case Management: Helps You Put the Pieces Together - Booklet, October 2007 (PDF, 660KB, 12pg.)
  - Case Management: Helps You Put the Pieces Together - Booklet, October 2007 (Spanish) (PDF, 253KB, 10pg.)
  - Taking Care of Ourselves: Mental Health and People Living with HIV/AIDS - Booklet, June 2007 (PDF, 8.2MB, 19pg.)
  - NYS Confidentiality Law and HIV Questions and Answers - Brochure, May 2006 (PDF, 53KB, 11pg.)
  - NYS Confidentiality Law and HIV Questions and Answers - Brochure, May 2006 (Spanish) (PDF, 90 KB, 11pg.)
  - HIV and Cancer: What's the Link? - Booklet, March 2006 (English) (PDF, 218KB, 16pg.)
  - HIV and Cancer: What's the Link? - Booklet, March 2006 (Spanish) (PDF, 241KB, 15pg.)
  - How to Get to a Place Called Home: A Handbook to Help People Living with HIV/AIDS Find Housing in New York City - Booklet, March 2006 (English) (PDF, 2MB, 87pg.)

- How to Get to a Place Called Home: A Handbook to Help People Living with HIV/AIDS Find Housing in New York City - Booklet, Nov. 2006 (Spanish) (PDF, 788KB, 92pg.)
- How to Get to a Place Called Home: A Handbook to Help People with HIV/AIDS Find Housing in New York State- Booklet, March 2006 (English) (PDF, 2MB, 84pg.)
- How to Get to a Place Called Home: A Handbook to Help People with HIV/AIDS Find Housing in New York State - Booklet, Nov. 2006 (Spanish) (PDF, 826KB, 90pg.)
- HIV and Smoking: It's Time to Live - Booklet, March 2006 (English) (PDF, 4MB, 12pg.)
- HIV and Smoking: It's Time to Live - Booklet, March 2006 (Spanish) (PDF, 2.10MB, 12pg.)
- Tuberculosis and HIV Fact Sheet - December 2005 (English) (PDF, 37KB, 2pg.)
- Good Oral Health is Important - Booklet, March 2004 (English) (PDF, 1.33MB, 11pg.)
- Good Oral Health is Important - Booklet, June 2004 (Spanish) (PDF, 576KB, 11pg.)
- Oral Health is Important: A guide for caregivers of children with HIV infection - Booklet, February 2004(English) (PDF, 231KB, 4pg.)
- Oral Health is Important: A guide for caregivers of children with HIV infection - Booklet, March 2004 (Spanish) (PDF, 121KB, 4pg.)
- Food, Health and You - Living with HIV - Booklet, December 2004 (English) (PDF, 2MB, 12pg.)
- Food, Health and You - Living with HIV - Booklet, December 2004 (Spanish) (PDF, 485KB, 12pg.)

- **HIV/AIDS Consumer Educational Materials Order Form**
  - Ordering Information for HIV/AIDS Educational Materials for Consumers

The Plan believes that these publications provide state-of-the-art clinical protocols for the treatment of HIV+ persons. Plan providers are instructed to order the most current publication of each guideline directly from the AIDS Institute, as appropriate to your specialty. Publications are free of charge. An order form is in Tab # 21 in the Appendix section.

## 22.6 HIV TESTING

Providers should be aware of the changes to the New York HIV Testing law that took effect September 2010. These changes made testing more available.

Key provisions include:

- Primary care providers, inpatient hospitals, and emergency departments are required to offer testing;
- Prior to consent or testing, the person ordering the test will discuss with the patient with seven key points of information (see section 22.2 above for details);
- Post-test messages are tailored to the patient's status;
- Negative post-test messages must emphasize identified risk behaviors;
- If the test is positive, the ordering provider must arrange for follow-up care (if the member consents);
- Informed consent has been simplified; it can be part of a general consent for treatment;
- Documented oral consent is acceptable for a rapid HIV test;
- Patients can still decline consent for HIV testing.

See http://www.health.ny.gov/diseases/aids/testing/law/docs/slide_presentation.pdf for a presentation on these changes.

## 22.7 RAPID HIV TEST

Providers who want to implement a rapid HIV testing program in their practice should consult http://www.health.ny.gov/diseases/aids/testing/rapid/workbook.htm for detailed guidelines.

## 22.8 SUBJECT: EXPANDED SYRINGE ACCESS PROGRAM (ESAP)

As part of its Quality Assessment Performance Improvement program, the Plan adopted guidelines to assist all its providers in the management and treatment of HIV positive members and members with AIDS. Since HIV disease transmission also occurs through use of contaminated needles and syringes, under the Public Health Law of New York State patients over the age of 18 and their partners can get syringes and needles through the ESAP program. There are also disposal and exchange sites located in New York. To learn more about this program refer patients to the New York State HIV/AIDS Information Hotline-1-800-541-2437.

## 22.9 *SUBJECT: CASE MANAGEMENT*

The Plan offers case management services for our members with disabilities or complex or chronic health care needs including diabetes, HIV/AIDS and asthma. If you are caring for a member who you believe could benefit from case management services, please call the Plan's Care Coordination at 1-800-765-3805 (NHP) or 1-800-250-5007 (SHP). Options for members with complex chronic, life threatening, or degenerative and disabling conditions or diseases include use of a specialist as a PCP, a standing referral to a specialist, a referral to a specialty care center, and use of a non-participating provider. Please see Care Coordination section 12 for more detail on Case Management (segment 12.4).

## 22.10 *PRACTICE GUIDELINE: Primary Care Approach to the HIV-Infected Patient*

### 22.10.1 INTRODUCTION

**Recommendations:**

Both HIV Specialists and primary care clinicians should be capable of evaluating HIV-infected patients at all stages of HIV infection. Primary care clinicians should consult with an HIV Specialist when initiating or changing treatment.

Clinicians should involve patients in decisions regarding HIV treatment. Clinicians should schedule routine monitoring visits at least every 4 months for all HIV-infected patients who are clinically stable.

As the treatment of HIV has continued to reduce mortality and increase the number of clinically stable patients, the primary care approach to HIV-infected patients has evolved. In addition to the management of HIV infection, a renewed emphasis on general preventive medicine has emerged.

The recommendations in this chapter are intended for the management of both HIV-infected patients who are receiving ARV therapy and those who are not. The following aspects of care are discussed:

- Medical history and physical examination
- Laboratory assessments and diagnostic testing
- Health maintenance and preventive care

- Coordination of care
- Use of chronic care services

All patients who are clinically stable should be monitored at least every 4 months; this includes both patients who are receiving ARV therapy and those who are not. Visits may need to be scheduled more frequently at entry to care, for management of acute problems, or when starting or changing ARV regimens.

For ARV treatment considerations, see *Antiretroviral Therapy* (or copy and paste: http://www.hivguidelines.org/clinical-guidelines/adults/antiretroviral-therapy/) which includes recommendations regarding initiation of ARV therapy, selection of an ARV regimen, monitoring for ARV-specific side effects, optimizing treatment adherence, and changing regimens.

## 22.10.2 BASELINE HISTORY

**Recommendations:**

Clinicians should obtain an HIV-related history at baseline.

Clinicians should use vocabulary, both orally and in written form, that is well organized and that patients can understand, regardless of education level, when obtaining the history. When language barriers exist, clinicians should use translator or sign language services.

Clinicians should obtain medical records from past medical providers, including documentation of a positive HIV ELISA antibody test result or a positive rapid test result that was confirmed by serum Western blot.

Clinicians should address the importance of partner notification and stress the confidential nature of discussions regarding sexual history and substance use.

Effective communication between the patient and provider can ensure that the clinician obtains an accurate and complete history.

Although clinicians may obtain all elements of a comprehensive history during the first few visits to the clinic, it is important to address sexuality and non-prescription drug use during the initial clinical encounter. The confidential nature of these discussions should be stressed. Clinicians should note that although the patient may choose not to disclose all pertinent personal information during the first visit, a sympathetic and nonjudgmental attitude can help establish trust and facilitate discussion of these issues during subsequent visits. Patient disclosure of sexual history and substance use should be when the patient feels safest and most comfortable to do so.

When obtaining a sexual history, labels to which the patient may not relate, such as lesbian, homosexual, or gay, should be avoided. Questions should relate to the patient's behavior and not to "sexual identity." The information derived will be more useful to the clinician and the questions less threatening to many at-risk patients. For example, when

talking to a male patient, the clinician should ask, Do you have sex with men?, and not, Are you a homosexual? or Are you gay?, because the patient may not identify with the words "homosexual" or "gay."

When assessing alcohol and substance use, clinicians should avoid judgmental language that can exacerbate stigma, such as "substance abuse" or "alcohol abuse." Instead of asking, Do you drink?, the clinician can ask, What do you like to drink: beer, wine, or liquor? A clinician's use of street terms for substances and substance use can also help promote honest responses from patients. Example: So when was the last time you smoked any weed?, may get a more accurate answer than, Do you use marijuana?. Phrasing a question with "even once," such as, Did you ever even once shoot up to get high?, may provide useful information for the clinician.

Clinicians who are uncomfortable asking questions about substance and alcohol use or different sexual behaviors should seek training to enhance their comfort level. For information regarding risk-reduction counseling related to sexual transmission of HIV, refer to the *HIV Prevention Guidelines: Prevention of HIV Transmission*. For scripted dialog for assessing substance use, refer to the HIV and *Substance Use Guidelines: Screening and Ongoing Assessment for Substance Use* (or copy and paste: http://www.hivguidelines.org/clinical-guidelines/hiv-and-substance-use/screening-and-ongoing-assessment-for-substance-use/)

## 22.10.3 COMPREHENSIVE PHYSICAL EXAMINATION

**Recommendation:**

Clinicians should perform a baseline and annual comprehensive physical examination, with particular attention to areas potentially affected by HIV.

*A. Vital Signs, Symptoms, and General Appearance*

Recommendations:

Clinicians should assess vital signs and weight at each visit.

Clinicians should inquire about new symptoms at each visit.

Clinicians should note changes in general appearance, body habitus, and physical well-being.

Vital signs, symptoms, and general appearance should be assessed at each visit. Weight should be included because weight gain or loss can be the first sign of therapy success or failure, even before laboratory test results are available.

Assessment of symptoms may require direct questioning because patients may not consider their symptoms important until significant morbidity has occurred, or they may simply forget to tell the clinician about new symptoms during the visit.

*B. Pain Assessment*

Recommendations:

Clinicians should ask HIV-infected patients about pain at each visit, as well as document any complaints of pain, attempt to identify underlying causes, and respond with efforts to alleviate it.

Clinicians should not deny treatment of pain because of a patient's history of addiction.

Clinicians should assess patients with chronic pain for fatigue and mental health disorders and include referral to a pain-management specialist as a treatment option.

HIV-infected patients are at increased risk for development of certain painful conditions, particularly neuropathy, which can be due to medications, diabetes, or the underlying HIV infection. Some opportunistic infections are painful, such as chronic herpes simplex virus or varicella zoster virus. Treatment of pain can be complicated if the patient has a history of substance use, and the extended use of opioid analgesics and benzodiazepines may require consultation with substance use treatment professionals. However, no patient should be denied treatment for pain because of a history of substance use. For further guidance on pain management in HIV-infected substance users, refer to the *HIV and Substance Use Guidelines: Pain in the HIV-Infected Substance User* (http://www.hivguidelines.org/clinical-guidelines/hiv-and-substance-use/pain-in-the-hiv-infected-substance-user/)

*C. Ophthalmologic Assessment and Referral*

Recommendations:

Patients with CD4 counts <50 cells/mm$^3$ should be examined by an ophthalmologist at baseline and every 6 months.

Patients with visual disturbances or unremitting ocular symptoms, regardless of CD4 cell count, should be evaluated by an ophthalmologist.

Eye examinations by an ophthalmologist, ideally one experienced with the ocular complications of HIV infection, are important, especially for patients at higher risk for CMV retinitis resulting from declining immune function. This examination should include a dilated funduscopic assessment with indirect ophthalmoscopy. See *Ophthalmologic Complications of HIV Infection* (http://www.hivguidelines.org/clinical-guidelines /adults/ophthalmologic-complications-of-hiv-infection/).

*D. Oral Examination*

Recommendation:

Clinicians should ascertain whether their patients have a regular oral health provider and should refer all HIV-infected patients for annual hygiene and intraoral examinations, including dental caries and soft-tissue examinations.

Clinicians should make an annual dental referral for every HIV-infected patient under their care. As part of the annual physical examination, the clinician should visually examine and palpate the patient's lips, labial and buccal mucosa, all surfaces of the

tongue and palate, and the floor of the mouth. The gingiva should be examined for signs of erythema, ulceration, or recession. Appropriate access to urgent dental care should be identified. See *Oral Health Complications In The HIV-Infected Patient* (http://www.hivguidelines.org/clinical-guidelines/adults/oral-health-complications-in-the-hiv-infected-patient/)

*E. Dermatologic Examination*

Dermatologic findings, such as rash, lesions of Kaposi's sarcoma, and vasculitis, may all be the first signs of progression of HIV, comorbid diseases, or toxicities of treatment. Seborrheic dermatitis can be an indicator of immune deficiency. Maceration of the gluteal cleft may not be noticed by the patient but could be a result of *Candida* infection or herpes simplex virus. Molluscum contagiosum may appear slightly larger and in more clusters in HIV-infected patients. Onychomycosis may involve all fingernails and toenails. Diffuse folliculitis with associated pruritus may occur with immunodeficiency.

*F. Lymph Node Examination*

Generalized lymphadenopathy is a common finding during all stages of HIV disease. Reactive lymph nodes may be prominent in early stages of HIV, diminish as disease progresses, and return with immune reconstitution after effective ARV treatment has been established. Presentation of asymmetry, clusters of large nodes, or sudden

increase in size, firmness, or tenderness of nodes may signal infection, malignancy, or opportunistic infections. Lymph node clusters that are normally quiescent, including posterior cervical chain, submental, supraclavicular, epitrochlear, axillary, and femoral nodes, should not be overlooked.

*G. Chest Examination*

The chest examination should include cardiac and pulmonary assessments. HIV infection can cause cardiac abnormalities; however, the prevalence of cardiac disease in HIV-infected individuals is not clear. Pericardial effusion and myocarditis are among the most commonly reported abnormalities, although cardiomyopathy, endocarditis, and coronary vasculopathy also have been reported. The evaluation of respiratory symptoms in HIV-infected patients can be challenging because they may be due to a wide spectrum of illnesses, which may or may not be related to HIV. HIV-related conditions include both opportunistic infections and neoplasms.

*H. Abdominal Examination*

Hepatosplenomegaly may be caused by infection, medications, alcohol, or other infiltrative disease processes. Certain combinations of HAART may increase the likelihood of finding multiple lipomata in the subcutaneous fat. Increased visceral fat associated with HAART may cause abdominal distension, requiring radiologic imaging to evaluate for other processes such as ascites.

*I. Genital and Rectal Examination*

Recommendations:

Clinicians should examine all HIV-infected patients for ulcerative lesions.

Clinicians should perform a gynecologic examination in all HIV-infected women or refer them to a gynecologist at baseline and at least annually.

At baseline and as part of the annual physical examination for all HIV-infected adults, regardless of age, clinicians should:

- Inquire about rectal symptoms, such as itching, bleeding, diarrhea, or pain
- Perform a visual inspection of the perianal region
- Perform a digital rectal examination

Clinicians should refer women with cervical HSIL and any patient with abnormal anal physical findings, such as warts, hypopigmented or hyperpigmented plaques/lesions, lesions that bleed, or any other lesions of uncertain etiology, for high-resolution anoscopy and/or examination with biopsy of abnormal tissue.

Because patients may be reluctant to report signs or symptoms of sexually transmitted infections (STIs) or other genital abnormalities, it is important that clinicians examine for vaginal or penile discharge and carefully inspect the anogenital area, including the vulva and vagina in women, for ulcerative lesions. Lesions attributable to HPV, syphilis, and classic herpes simplex virus (HSV) should be examined for, as well as atypical HSV presentations, such as non-healing gluteal cleft maceration. In addition to a genital examination, a careful pelvic examination is essential for women.

During the rectal examination, evidence of skin abnormality around the anus should be referred for high-resolution anoscopy (HRA) and/or examination with biopsy of abnormal tissue. For additional information, see *Neoplastic Complications of HIV Infection* (http://www.hivguidelines.org/clinical-guidelines/adults/neoplastic-complications-of-hiv-infection/).

*J. Neuropsychological Examination*

*1. Neurologic Examination*

Recommendations:

Clinicians should examine for sensory and motor abnormalities, cerebellar function, motor and sensory abnormalities, especially peripheral neuropathy, and cognitive

impairment.

Clinicians should refer patients with more complex suspected or proven peripheral neuropathy syndromes to a neurologist to assist with the diagnosis and management.

HIV-related neurologic changes can occur, even without the neurologic side effects of medications, especially as the infection progresses. For further information regarding neurologic complications, including screening tools for cognitive impairment, see *Neurologic Complications of HIV Infection* (http://www.hivguidelines.org/clinical-guidelines/adults/neurologic-complications-of-hiv-infection/) and the *HIV and Mental Health Guidelines: Cognitive Disorders and HIV/AIDS: HIV-Associated Dementia and Delirium* (http://www.hivguidelines.org/clinical-guidelines/hiv-and-mental-health/cognitive-disorders-and-hivaids-minor-cognitive-disorder-hiv-associated-dementia-and-delirium/).

*2. Mental Health and Substance Use Assessment*

Recommendations:

Clinicians should perform a mental health assessment at baseline and at least annually. The assessment should include the following components (**I**):

- Depression, anxiety, post-traumatic stress disorder, suicidal/violent ideation, and substance use
- Sleep habits and appetite assessment
- Psychiatric history, including psychotropic medications
- Psychosocial assessment, including domestic violence and housing status

Clinicians should refer patients to appropriate mental health and substance use treatment providers when indicated.

Clinicians should incorporate selected brief screening instruments into the assessment process. The chosen screening instruments should be tailored for optimal use at initial, annual, and interim visits and adjusted for the patient’s mental health or substance use history.

A number of mental health and substance use screening tools are available for use by primary care providers. For further information on mental health screening and treatment, refer to the *HIV and Mental Health Guidelines (http://www.hivguidelines.org/clinical-guidelines/hiv-and-mental-health)* and *Screening Tools for Completing Mental Health Assessments in HIV Primary Care Settings (http://www.hivguidelines.org/clinical-guidelines/hiv-and-mental-health/mental-health-screening-a-quick-reference-guide-for-hiv-primary-care-clinicians/)* &

*(http://www.hivguidelines.org/clinical-guidelines/hiv-and-mental-health/appendix-i-mental-health-screening-tools/* . For further information on substance use screening and treatment, refer to the *HIV and Substance Use Guidelines: Screening and Ongoing Assessment for Substance Use* (http://www.hivguidelines.org/clinical-guidelines/hiv-and-mental-health/appendix-i-mental-health-screening-tools/).

## 22.10.4 LABORATORY ASSESSMENT AND DIAGNOSTIC TESTING

Recommendation:

Clinicians should order appropriate laboratory assessments and screening tests for management of HIV-infected patients.

*A. Immunologic Assessment*

Recommendation:

The CD4 lymphocyte profile should include both the absolute count and percentage.

A decline in absolute CD4 count may occur in some situations, such as after interferon therapy, when all lymphocyte populations are suppressed; however, the percentage of CD4 lymphocytes will remain relatively constant. A stable CD4 percentage generally indicates stable immune function even in the presence of declining absolute counts.

*B. Virologic Assessment*

Recommendations:

Clinicians should use a standard viral load assay, not an ultrasensitive test, for initial measurement of HIV viral load in an ARV therapy-naïve individual.

Clinicians should obtain viral load before vaccinations and not during intercurrent illness because these situations may lead to a transient elevation in viral load.

Clinicians should perform resistance testing under the following circumstances:

- At baseline in the setting of acute HIV infection, regardless of whether ARV therapy is being initiated (genotypic testing)
- In ARV therapy-naïve patients before initiation of ARV therapy (genotypic testing)
- In patients experiencing treatment failure or incomplete viral suppression while receiving ARV therapy (genotypic and/or phenotypic testing)

Clinicians should seek expert consultation for interpretation of genotypes.

There are several methods of measuring HIV viral load levels (e.g., PCR, bDNA, NASBA), each with different ranges (e.g., standard, ultrasensitive). The same assay should be used consistently to avoid confusion. The range of detection for the standard PCR assay is 400 to 750,000 copies/mL, whereas the range for the ultrasensitive assay is 50 to 75,000 copies/mL. The initial test performed in an ARV therapy-naïve individual should be a standard assay in order to document a potentially high viral load level. All patients with a viral load <400 copies/mL according to the standard assay should be re-tested using the ultrasensitive assay (see *Diagnostic, Monitoring, and Resistance Tests for HIV*: http://www.hivguidelines.org/clinical-guidelines/adults/diagnostic-monitoring-and-resistance-tests-for-hiv/).

Resistance testing should be performed 1) at baseline in the setting of acute infection, regardless of whether ARV is being initiated (genotypic testing); 2) prior to initiating treatment in ARV therapy-naïve patients to determine whether they are infected with drug-resistant virus (genotypic testing); and 3) in patients experiencing virologic failure or incomplete viral suppression while receiving ARV therapy (genotypic and/or phenotypic testing). Most currently available assays require a viral load level of >500 to 1000 copies/mL for detection. For more information regarding resistance testing, refer to the section *HIV Resistance Assays* in *Antiretroviral Therapy* *(http://www.hivguidelines.org/clinical-guidelines/adults/antiretroviral-therapy/#3.HIV Resistance Assays)*.

*C. Tuberculosis Evaluation*

Recommendations:

Clinicians should obtain a TST (tuberculin skin test, commonly known as PPD) or other FDA-approved test for diagnosis of latent tuberculosis infection, unless the patient has previously tested positive or has had previously documented TB.

After active tuberculosis has been excluded, clinicians should prescribe TB prophylaxis when a TST results in induration of ≥5 mm or when another FDA-approved test indicates the presence of latent TB infection.

Induration of ≥5 mm with a TST (tuberculin skin test, commonly known as PPD) is considered a positive reaction in the HIV-infected population and warrants prophylaxis. In general, anergy testing is no longer recommended. See Mycobacterial Infections (http://www.hivguidelines.org/clinical-guidelines/adults/infectious-complications-associated-with-hiv-infection/mycobacterial-infections/).

*D. Laboratory Screening for Sexually Transmitted Infections*

Recommendation:

Clinicians should screen HIV-infected patients for syphilis by obtaining a non-treponemal test (RPR or VDRL) with verification of reactive test by confirmatory fluorescent treponemal antibody absorbance (FTA-Abs) or treponema pallidum particle

agglutination (TP-PA) tests at baseline and at least annually. Patients with continued high-risk behavior should be screened for syphilis every 3 months.

Clinicians should screen sexually active HIV-infected women under the age of 25 for gonorrhea and chlamydia at baseline and at least annually. Clinicians should screen all sites of possible exposure, including the cervix, rectum, and pharynx. Culture or nucleic acid amplification tests (NAT) should be used to screen for gonorrhea. Immunofluorescence or DNA amplification should be used for chlamydia.

Clinicians should screen women 25 years of age or older for gonorrhea and chlamydia at baseline and at least annually if they have or have had a recent sexually transmitted infection, have multiple sexual partners, have had a new sexual partner, or have a sexual partner with symptoms of an STI.

Clinicians should screen all HIV-infected men with ongoing high-risk sexual behaviors for gonorrhea and chlamydia at baseline and at least annually. Clinicians should screen all sites of possible exposure, including the urethra, rectum, and pharynx.

The FTA-Abs and TP-PA confirmatory tests remain positive for life if there has been a history of syphilis infection. Some individuals previously treated for syphilis will continue to have a low serum antibody-positive RPR or VDRL. A 4-fold increase in RPR serum antibody indicates acute infection or re-infection with syphilis.

Refer to Management of STIs in HIV-Infected Patients (http://www.hivguidelines.org/clinical-guidelines/adults/management-of-stis-in-hiv-infected-patients/) for more information about screening for STIs.

*E. Cytologic Screening*

*1. Cervical Pap Tests*

Recommendations:

Clinicians should obtain cervical Pap tests for all HIV-infected women at baseline, 6 months after baseline, and then repeat annually, as long as results are normal. Colposcopy should be performed for women with abnormal Pap tests. Follow-up would then vary on a case-by-case basis.

Clinicians should repeat abnormal Pap tests every 3 to 6 months thereafter until there have been two successive normal cervical Pap tests. Women with cervical HSIL also should be referred for high-resolution anoscopy and/or examination with biopsy of abnormal tissue.

Clinicians should obtain at least an annual Pap test in HIV-infected women who have undergone either a supracervical or total hysterectomy.

The purpose of cervical screening is to prevent the development of invasive cancer by identifying and treating individuals with precursor lesions that are at risk for progression to cancer. Widespread screening of all women with cervical cytology or Pap tests has

led to a decline in morbidity and mortality from cervical cancer. The benefit of screening and treatment protocols for cervical abnormalities in HIV-infected women is also well-established. Although cervical cytology (Pap tests) has lower sensitivity compared to actual tissue histology, colposcopy with Pap tests has increased the effectiveness of the evaluation of women with HIV infection, particularly those women with a report of atypical squamous cells of undetermined significance (ASC-US) by delineating likely abnormal tissue for biopsy and histologic evaluation.
Recurrent dysplasia on the vaginal cuff can be seen in women with a history of cervical dysplasia, and both HIV and HPV infections increase the risk of vaginal intraepithelial neoplasia. Therefore, women who have undergone a hysterectomy should still receive annual Pap tests.

*2. Anal Pap Tests*

Recommendations:

Clinicians should obtain anal cytology at baseline and annually in the following HIV-infected populations:

- Men who have sex with men
- Any patient with a history of anogenital condylomas
- Women with abnormal cervical/vulvar histology

Clinicians should refer patients with abnormal anal cytology for high-resolution anoscopy and/or examination with biopsy of abnormal tissue.

Like cervical cancer, invasive squamous cell cancers of the anal canal are associated with certain types of human papillomavirus (HPV) infection, most notably, HPV-16 and HPV-18. Although this is a new practice that may not be routinely available, screening for cellular dysplasia is prudent and recommended, particularly in persons at high risk for infection with papilloma viruses. For additional information, see *Neoplastic Complications of HIV Infection* (http://www.hivguidelines.org/clinical-guidelines/adults/neoplastic-complications-of-hiv-infection/).

## 22.10.5 HEALTH PROMOTION AND BEHAVIORAL HEALTH COUNSELING

Recommendation:

Clinicians should provide routine HIV risk-reduction counseling and behavioral health counseling for HIV-infected patients.

Patients' behaviors change over time as the course of their disease changes and their social situations vary. The clinician will need to tailor routine risk-reduction counseling and behavioral health counseling not only to the individual patient but also to the particular point in time in the patient's life.

*A. Safer Sex Education*

Recommendations:

Clinicians should discuss safer sexual practices with HIV-infected patients on a routine and ongoing basis.

Clinicians should routinely discuss with patients the importance of disclosure to partners. Patients should be educated about the options for voluntary partner notification. These discussions should be clearly documented. Information about HIV reporting and partner notification in New York State is available at www.health.state.ny.us.

Clinicians should emphasize that transmission of HIV may occur during unprotected sex, even when patients have undetectable HIV plasma viral loads.

Clinicians should recommend the correct and consistent use of latex or, when latex allergies exist, polyurethane male condoms and should discuss the option of using polyurethane female condoms.

Clinicians should instruct patients in the proper use of condoms, dental dams, and other barriers to reduce the risk of HIV transmission.

Clinicians should educate their patients to avoid using condoms and creams containing nonoxynol-9.

For patients who are sexually active, discussion should include a review of safer practices to prevent the transmission of HIV or other STIs. It is important to note that risk for transmission of HIV is increased in the setting of STIs, underscoring the importance of correct and consistent use of barrier protection during vaginal, rectal, or oral intercourse. Patients should be informed that because condoms do not cover all exposed areas, they are more effective in preventing infections transmitted by fluids from mucosal surfaces than in preventing infections transmitted by skin-to-skin contact.

The use of both male and female condoms among patients should be encouraged, despite adverse attitudes toward them in some communities. Condoms should be offered along with instructions, support, counseling, and referral to community-based organizations.

Clinicians should also inform patients that condoms containing nonoxynol-9, a topical spermicide used to prevent conception, should be avoided. In at least one large placebo-controlled study of sex workers using nonoxynol-9, there was an increase in new HIV infection.

*B. Substance Use Counseling*

Recommendations:

When current alcohol or other substance use is identified, clinicians should discuss the possible effects of such use on the patient's general health and HIV medications, as well as options for treatment if indicated. These discussions should be properly documented in the patient's chart.

Clinicians should evaluate for possible interactions among illicit drugs and prescription drugs.

Clinicians should issue prescriptions for new needles and syringes to patients who inject drugs.

Clinicians should discuss with patients other options for accessing new needles and syringes, including use of the Expanded Syringe Access Demonstration Program and Syringe Exchange Programs, New York State's two syringe access initiatives.

Clinicians should collaborate with social work staff and other mental health providers, when available, to determine which treatment programs or substance use services best meet the patient's needs.

The HIV and Substance Use Guidelines (http://www.hivguidelines.org/clinical-guidelines/hiv-and-substance-use/aspects-of-primary-care-for-the-hiv-infected-substance-user/ contains information on the management of HIV-infected substance users. For specific information regarding interactions between illicit drugs and prescription drugs, refer to the HIV and Substance Use Guidelines: Drug-Drug Interactions Between ARV Agents, Medications Used in Substance Use Treatment, and Recreational Drugs (http://www.hivguidelines.org/clinical-guidelines/hiv-and-substance-use/drug-drug-interactions-between-arv-agents-medications-used-in-substance-use-treatment-and-recreational-drugs/).

*C. Tobacco Use Assessment and Counseling*

Recommendation:

Clinicians should assess smoking status and should encourage those who smoke to stop (I). Pharmacotherapy and referrals to smoking cessation programs should be provided if the patient is interested.

Smoking increases a patient's risk of developing thrush, cryptococcal meningitis, bacterial pneumonias, and coronary artery disease. In addition, HIV infection further increases the risk of lung and other cancers associated with smoking.

Smoking cessation interventions delivered during routine visits will reach many smokers who are already receiving care for their HIV infection. Patients who are interested in quitting smoking within the next month should be helped to set a quit date, offered pharmacotherapy with nicotine replacement or bupropion, and referred to a counseling program. For further guidance on smoking cessation, refer to Smoking Cessation in HIV-Infected Patients (http://www.hivguidelines.org/clinical-guidelines/hiv-and-substance-use/drug-drug-interactions-between-arv-agents-medications-used-in-substance-use-treatment-and-recreational-drugs/).

*D. Reproductive Counseling*

Recommendation:

Clinicians should discuss family planning with patients, including risks to the mother and fetus during pregnancy.

Many patients have questions about having children even though they or their partners are infected with HIV. Risks to the mother and fetus, as well as the risk of HIV transmission through breastfeeding, should be discussed. Alternative or supplemental family planning methods beyond condom use may also be addressed.

For additional information, refer to the Women's Health Guidelines: Preconceptional Care for the HIV-Infected Woman.

*E. Domestic Violence*

Recommendations:

Clinicians or a member of the healthcare team should screen all male and female HIV-infected patients for current and lifetime domestic violence at baseline and annually.

Prior to screening patients for domestic violence, clinicians should discuss confidentiality and exceptions to confidentiality, including instances of suspected child abuse and maltreatment and intent to harm self or others.

Domestic violence screening should be performed only when the patient is alone.
When real or potential domestic violence is recognized, social work services should be involved and referrals should be made to domestic violence organizations or domestic violence counseling. In the absence of social work services, clinicians should be familiar with resources available in the community and mechanisms of referral.

The following are questions that may be used for screening:

1. Do you ever feel unsafe at home?
2. Are you in a relationship in which you have been physically hurt or felt threatened?
3. Have you ever been or are you currently concerned about harming your partner or someone close to you?

Other questions regarding sexual abuse, such as forced sexual activity, coercion, etc., may be applicable depending on the case.

For more information regarding assessment for domestic violence, refer to the New York State Office for the Prevention of Domestic Violence, available at: www.opdv.state.ny.us/health_humsvc/health/index.html.

*F. Psychosocial Assessment*

Recommendations:

The clinician or a member of the healthcare team should perform a psychosocial assessment of HIV-infected patients, including housing status, at baseline and at least annually.

The clinician should work with the patient's case manager to provide necessary medical guidance related to psychosocial issues that are potential barriers to treatment adherence.

When case managers are unavailable, clinicians will need to be able to refer their patients to social workers who can provide psychosocial services and facilitate referrals to supportive services.

*G. Diet and Exercise Counseling*

Diet and exercise counseling can enhance the management of and the patient's knowledge about the risks associated with diabetes, hypertension, problems associated with lipid abnormalities, and potential side effects of medications.

For more information regarding nutrition among HIV-infected patients, refer to General Nutrition, Weight Loss, and Wasting Syndrome (http://www.hivguidelines.org/clinical-guidelines/adults/general-nutrition-weight-loss-and-wasting-syndrome/).

## i. PREVENTIVE MEDICINE

*A. Standard Health Maintenance*

Recommendations:

Clinicians should discuss general preventive health care and health maintenance with all HIV-infected patients routinely and, at a minimum, annually.

Clinicians should perform standardized age- and sex-appropriate health-maintenance interventions, such as cancer screening, in HIV-infected patients according to the same guidelines used for non-HIV-infected patients.

Clinicians should instruct patients on how to perform breast and testicular self-examinations.

Colorectal Cancer

Colorectal cancer is the second leading cause of cancer death in the United States. According to the United States Preventive Services Task Force, universal screening for colorectal cancer in the general population should begin at age 50 in the absence of specific risk factors, such as previous colorectal cancer, strong family history, familial polyposis, or inflammatory bowel disease. Some data support screening African Americans aged ≥45 because they have a younger mean age of onset of colorectal cancer compared with other groups and a greater incidence of cancerous lesions in the proximal large bowel.

*B. Opportunistic Infection Prophylaxis*

Recommendations:

Clinicians should initiate prophylaxis for specific opportunistic infections and discontinue them when as indicated.

Prophylaxis for opportunistic infections may be withdrawn for patients who are on effective ARV therapy and who have evidence of recovery of immunologic competence.

For more information on management of opportunistic infections, see Infectious Complications Associated With HIV Infection (http://www.hivguidelines.org/clinical-guidelines/adults/infectious-complications-associated-with-hiv-infection/).

*C. Immunizations*

Immunizations against infectious diseases are an extremely important component of care for patients with immune suppression. Concerns regarding vaccinations in HIV-infected individuals include:

- The potential danger from live virus vaccines
- The ability of HIV-infected patients to mount an appropriate immune response to vaccine

In general, the more intact the immune system is, the more effective and safe the vaccines are. The use of live virus vaccines is generally undertaken when an inactivated version does not exist and when the risk of the disease clearly outweighs the theoretical risk of vaccination.

For more information regarding immunizations, including immunizations for pregnant

HIV-infected women, refer to the HIV Prevention Guidelines: Prevention of Secondary Diseases (http://www.hivguidelines.org/clinical-guidelines/hiv-prevention/prevention-of-secondary-disease-preventive-medicine/).

### ii. COORDINATION OF CARE

Recommendations:

As part of the initial visit, the clinician or other member of the healthcare team should educate new patients about the following items:

- How to access emergency services (provide a phone number for 24-hour services)
- Whom to contact to schedule appointments
- How to obtain laboratory and radiology results, medical records, and other reports

After receiving patient consent, clinicians should share information with other agencies from which their patients are receiving services.

Case management should be used to enhance coordination of care provided by agencies such as home care, nutrition services, and nursing services and to prevent duplication of services.

Clinicians should regularly involve case managers in case conferences to discuss psychosocial issues that may affect a patient's ability to adhere to care.

Comprehensive HIV care often involves multidisciplinary care with involvement of more than one provider. To facilitate adherence to all facets of care, the clinician should work with the case management team to coordinate medical care, referrals, and ongoing services in the community.

### iii. APPROPRIATE USE OF ACUTE CARE SERVICES

Recommendations:

Outpatient clinicians who do not provide inpatient care should have a network of practitioners with whom they can communicate easily should their patients require hospitalization.

Inpatient clinicians should ensure that the details of hospitalization, including the discharge medications and plans, are sent in a timely fashion to outpatient clinicians.
Communication among practitioners is essential when patients move between primary care clinicians and other healthcare settings. When patients are referred to the emergency room, communication with the emergency room physician, both by phone and by transmission of essential data, such as pertinent medical conditions, the

medication list, the patient's most recent CD4 count and viral load, and any other pertinent clinical data, can improve the patient's care and help prevent unnecessary

testing or hospitalization. If the patient needs to be hospitalized and the primary care clinician is not the admitting physician, communication of these data to the admitting physician is essential.

### iv. APPROPRIATE USE OF CHRONIC CARE SERVICES

Communication is essential between outpatient practitioners and all professionals involved in the patient's care. This includes both nursing services and other consultants and ancillary providers such as physical therapists.

*A. AIDS Adult Day Health Care Program*

AIDS Adult Day Health Care Programs (ADHCs) are designed to assist in meeting the healthcare needs of patients with HIV/AIDS who require a greater range of comprehensive healthcare services than can be provided in any single ambulatory setting but who do not require the level of services provided in a hospital or skilled

nursing facility. Through a therapeutic environment, ADHCs are intended to improve and stabilize the health of patients with HIV/AIDS, assist patients with adherence support, reduce hospital stays, eliminate unnecessary visits to primary care clinicians and emergency rooms, and provide interventions in the form of one-on-one counseling and structured group activities for substance use and mental health disorders. Nursing care, nutritional services, case management, and HIV risk reduction, as well as auricular acupuncture and therapeutic massage, are also provided. For more information on these programs, contact (518) 474-8162.

*B. Home Health Care*

Recommendation:

Home health nurses should be provided with a copy of the patient's medication list and information regarding current medical conditions and mental health or substance use disorders.

Home care, including infusion therapy, can help maintain the patient's health and reduce the need for hospitalization. AIDS Home Care Programs (AHCPs) ensure patients' access to enhanced physician services, dental care, HIV prevention and education services, substance use and treatment services, pastoral care, mental health services, peer support, HIV clinical trials, and HIV therapies. AHCP services may be provided by a long-term home health care program or a Designated AIDS Center specifically authorized to provide these services.

AHCPs are responsible for arranging and/or providing the following: nursing services, home health aide services, medical supplies, equipment and appliances, physical and

occupational therapy, speech pathology, nutritional services, medical social services, personal care services, and housekeeping services. Long-term home health care programs may also provide personal emergency response, meals on wheels, housing improvement, home maintenance, moving assistance, social daycare, and social transportation services.

*C. End-of-Life Care*

Recommendations:

Clinicians should encourage patients to prepare an advanced directive and designate a health care proxy and should review these arrangements at least annually.

As HIV disease progresses, clinicians should discuss patients' feelings about end-of-life care before they are unable to make decisions. Any medical decisions that are made should be in conjunction with the patient, or, if the patient is unable to decide for neurologic reasons, with the patient's health care proxy.

Clinicians should be familiar with hospice services available in their area and should make referrals to them early enough for the patient to receive the full benefit of their support (III). Clinicians should work in conjunction with hospice staff to establish which medical interventions may still be appropriate as quality of life evolves or changes.

End-stage HIV infection often involves a series of treatments for opportunistic infections, tumors, or other life-threatening comorbid conditions, such as liver failure. When both the patient and the clinician agree that aggressive care is no longer desired or likely to succeed, supportive care with a goal to maximize comfort is appropriate.

Clinicians should work with hospice staff to establish which interventions may still be appropriate as quality of life declines. For example, continuing aggressive care of cytomegalovirus retinitis to prevent blindness is a treatment that may need to be continued even though the patient has elected to discontinue other active medications.