Practice Guidelines for the Care of Persons with HIV/AIDS

Ryan White HIV Treatment Extension Act of 2009

San Diego County

In conjunction with United States (U.S.) Public Health Service (PHS) guidelines and accepted community practices, the San Diego County HIV Planning Group's Medical Standards and Evaluation Committee recommends the following practice guidelines for the management of human immunodeficiency virus (HIV) infection in patients enrolled in the Ryan White Primary Care Program of San Diego County. These guidelines are intended to serve as a framework for provision of medical care to persons with HIV (PWH), with management based on a respect for patient autonomy and a shared decision-making process between providers and patients.

Antiretroviral therapy (ART) and opportunistic infection (OI) prophylaxis (primary and secondary) are recommended in accordance with the most recent PHS guidelines, and vaccines are recommended in accordance with the most recent Advisory Committee on Immunization Practices (ACIP) recommendations. Guidelines may have been updated since the versions listed below; current versions are available at https://clinicalinfo.hiv.gov/en/guidelines and https://www.cdc.gov/vaccines/acip/recommendations.html, respectively.

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

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

1) Complete history, to include at least the following:
   a. *General background:*
      - Race/ethnicity
      - Gender identity
      - Sex assigned at birth
      - Housing status
      - Family history
      - Social history
      - Travel history
      - Country of birth
   b. *Current/lifetime sexual history: (See Appendix A for example)*
      - Sexually transmitted infection/disease (STI/STD) history during lifetime and/or last 5 years
      - Relationship status
      - Detailed sexual history
      - Partner(s), including HIV status and, for partners living with HIV, engagement in HIV medical care
      - Exposure sites – anorectal, genital, oropharyngeal
      - Protection from HIV and STIs: including condoms, HIV pre-exposure prophylaxis (PrEP), and doxycycline STI post-exposure prophylaxis (i.e., Doxy-PEP)
      - Pleasure, performance, and any issues affecting these
   c. *Current/lifetime substance use history:*
      - Injection drug use (IDU), during lifetime and/or last 5 years
      - Non-injection drug use, during lifetime and/or last 5 years
      - Alcohol and/or drug treatment history
      - Sexual activity under the influence of substances
      - History of overdose or use of naloxone on self or others

- Tobacco use, during lifetime and/or last 5 years

d. *HIV care history:*
   - HIV status, including recent/historical CD4+ T-cell count/HIV-1 viral load results
   - Prior and current antiretroviral regimens
   - Resistance test results (if available)
   - Current prophylaxis
   - Prior HIV-related complications

e. *General medical history:*
   - Immunizations
   - Hepatitis history
   - Tuberculosis (TB) risk https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/tuberculosis_control_program/SD_TB%20Risk%20Assessment%202018.pdf
   - Reproductive history (persons assigned female at birth), including parity, last menstrual period (LMP), and method of birth control
   - Current allergies
   - Other current medications
   - Significant childhood illnesses
   - Surgical history
   - Mental health history, past/current mental health conditions, symptoms of depression, and psychiatric medications
   - Other medical history

2) Review of symptoms and general physical exam, including height, weight, temperature, blood pressure, pulse, respiratory rate, general appearance, skin, head, eyes, ears, nose and throat (HEENT), ophthalmoscopy, chest, heart, lungs, abdomen, rectum, anoscopy (if anorectal symptoms), pelvic (persons assigned female at birth), breasts, genitalia, extremities, lymph nodes, mental status, nervous system including reflexes

3) Laboratory tests

   a. For the current list of recommended labs and periodicity, please refer to PHS Guidelines for Laboratory Testing for Initial Assessment and Monitoring of Patients with HIV Receiving Antiretroviral Therapy.

   b. STI Testing
      - Should be performed at baseline and at least annually thereafter for sexually active clients, more frequently (e.g., every three months) if indicated based upon the client's sexual practices.
      - Syphilis serology
      - Gonorrhea/Chlamydia – Perform testing for all possible exposure sites (e.g., urogenital, throat, rectum) using nucleic acid amplification testing (NAAT). If antibiotic-resistant *Neisseria gonorrhoeae* is suspected, obtain *N. gonorrhoeae* culture from all exposure sites.
      - Trichomoniasis – Screening with NAAT should be performed annually for persons having vaginal sex.
      - Anal Pap test – See **Section H – Anal Cancer Screening**.
      - Resources:
        - Centers for Disease Control and Prevention (CDC) Recommendations for Providing Quality STD Clinical Services, 2020
        - CDC STI Treatment Guidelines, 2021
        - Updated CDC Gonorrhea Treatment Recommendations, 2020
        - California Department of Public Health Dear Colleague Letter: Doxycycline Post-Exposure Propohylaxis (doxy-PEP) for the Prevention of Bacterial STIs
        - CDC Recommendations for the Laboratory-Based Detection of *Chlamydia trachomatis* and *Neisseria gonorrhoeae*, 2014

   c. TB Testing
      - Annual screening in the form of Annual Risk Assessment: https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/tuberculosis_control_program/SD_TB Risk Assessment 2018.pdf

- Annual screening using purified protein derivative (PPD) or interferon-gamma release assay
  - If screening test is positive, the patient should have a chest x-ray.
- Chest x-ray: At least one should be documented in the medical record if the individual has a history of TB or a positive screening test.

d. Viral Hepatitis Testing

- Hepatitis B screening should be performed by testing for hepatitis B surface antibody (HBsAb), surface antigen (HBsAg), and antibody to core antigen (anti-HBc or HBcAb). Those who are susceptible to infection should be vaccinated against Hepatitis B Virus (HBV) (see **Section C – Guidelines for Immunization**). Patients who are negative for HBsAg and HBsAb but positive for anti-HBc should be screened for chronic HBV infection by determination of HBV deoxyribonucleic acid (DNA). Those without evidence of chronic infection should consider vaccination. https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-opportunistic-infection/hepatitis-b-virus-infection?view=full
- Hepatitis C screening with Hepatitis C Virus (HCV) antibody or, if recent (i.e., within last six months) infection is suspected, the patient has advanced immunodeficiency (CD4 count<100 cells/mm^3), or the patient has a history of successfully treated or spontaneously cleared HCV infection, ribonucleic acid (RNA) testing should be performed at baseline and at least annually for persons with ongoing risk factors (e.g., IDU) and sexually active men who have sex with men (MSM). HCV RNA should be ordered for all patients with a positive HCV antibody test to assess for active HCV disease. https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-opportunistic-infection/hepatitis-c-virus-infection?view=full

e. Other Testing:

- Measles antibody titer – All persons with HIV born in 1957 or after should be tested for immunity to measles by measuring antibody titers. The measles, mumps, and rubella (MMR) vaccine should be given to persons with CD4 ≥200 cells/mm^3 born in or after 1957 who have not received the vaccine or do not have immunity based on laboratory testing (see **Section C – Guidelines for Immunization**).

4) Appropriate referrals, including but not limited to:
   - Treatment adherence counseling
   - Ryan White dental program (recommended annually)
   - Ophthalmologist if CD4 <50 cells/mm^3 (recommended)
   - Case management (if eligible)
   - Medical nutrition therapy
   - Clinical trials
   - Mental health
   - Substance use treatment
   - Partner services/PrEP if client has not achieved sustained viral suppression

For a list of currently funded Ryan White Service Providers, please visit:
HIV Care and Services Resources (sandiegocounty.gov)

B. Guidelines for Plasma HIV RNA (i.e., Viral Load) Measurements, CD4 Counts, and HIV Genotype
https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/plasma-hiv-1-rna-viral-load-and-cd4-count-monitoring?view=full

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

is consistently >500cells/mm^3 and viral load has been undetectable for >2 years.

3) HIV-1 genotype – should be performed upon entry to care for patients who are treatment-naïve and for persons with viral load ≥1,000 copies/mL who have been on a stable ART regimen for 30 days prior to the date of the viral load test.

C. Guidelines for Immunization

Adult Immunization Schedule by Vaccine and Age Group | CDC
Vaccines Indicated for Adults Based on Medical Indications | CDC

1) Vaccines should be offered as soon as possible after initial evaluation at recommended doses.
2) Viral loads should not be measured within three weeks of an immunization.
3) Pneumococcus, influenza, tetanus, Hepatitis B (if not immune), Hepatitis A (if not immune), human papillomavirus (HPV), meningococcal, varicella zoster virus (VZV), vaccinia (mpox)
4) Influenza vaccine: recommended yearly with trivalent inactivated vaccine (live attenuated vaccine is contraindicated in persons living with HIV or PLWH). https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html
5) HPV: Recommended for all PWH through age 26 years as a three-dose series, regardless of the age at initial vaccination. Vaccination may be considered, based on shared clinical decision-making, for persons aged 27-45 years. https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hpv.html
6) VZV:
   a. Varicella vaccine: live attenuated varicella vaccine is recommended for PLH if they do not have immunity to VZV and have a CD4 count of at least 200 cells/mm^3 and a CD4 percentage of at least 15%. The vaccine does not need to be given to persons born in the U.S. before 1980. https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/varicella.html
   b. Recombinant zoster vaccine (RZV) is recommended for all adults with HIV aged 18 years and older, regardless of previous receipt of VZV vaccine, history of herpes zoster infection, or CD4 count (although immunologic response may be suboptimal for persons with CD4 count <200 cells/mm^3 and/or those who have not achieved viral suppression). https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/shingles.html
7) Hepatitis Vaccines:
   a. Hepatitis B: Recommended in persons with negative serology or isolated positive core antibody (i.e., negative surface antigen and antibody). Double dosing (i.e., 40µg) of single-antigen three-dose vaccines is recommended to increase seroconversion rates. For those patients who do not seroconvert after the first series, a second series is recommended. If these persons do not seroconvert, they are unlikely to respond to a third series. The safety and efficacy of the two-dose vaccine has not been evaluated in PLWH but is an option if a two-dose regimen is preferred. https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hepb.html
   b. Hepatitis A: Seroconversion rates are likely related to CD4 counts. The vaccine may be given in persons who are seronegative. However, if there is no response and the CD4 counts are less than 500 cells/mm^3, persons can receive a repeat series when CD4 counts are higher. https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hepa.html
8) Pneumococcal: All PLH should be up-to-date on pneumococcal vaccination according to ACIP recommendations. https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/pneumo.html
9) Meningococcal: Vaccination against serogroups A, C, W, and Y is recommended for all PLH aged ≥2 years. Vaccination against serogroup B is recommended for persons aged ≥10 years who are at increased risk for serogroup B meningococcal disease due to certain underlying conditions or a serogroup B outbreak. HIV disease is not one of the underlying conditions for which serogroup B vaccination is recommended. Serogroup B vaccination may be considered for adolescents and young adults aged 16-23 years on the basis of shared decision-making. https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mening.html
10) Tetanus vaccines: Recommended every 10 years. Recommend that the next booster contain pertussis booster (Tdap) (make sure the patient has had the pertussis vaccine).

https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/dtap.html

11) Mpox (formerly known as monkeypox): Vaccination with the JYNNEOS vaccine should be offered to all PLH who have not completed the series. https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/smallpox.html

12) SARS-CoV2 (Coronavirus Disease 2019 or COVID-19): COVID-19 vaccination is recommended for all PLWH, regardless of CD4 count or viral load, because the potential benefits outweigh the risks. PLWH should receive booster doses of COVID-19 vaccines as recommended by CDC. For people with untreated or advanced HIV, the CDC COVID-19 vaccination schedule for people with moderate to severe immunosuppression should be followed.

https://www.covid19treatmentguidelines.nih.gov/special-populations/hiv/

https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/covid-19.html

13) Respiratory syncytial virus (RSV): Vaccination is recommended for persons aged 60 years or older and pregnant persons based on shared decision making. https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/rsv.html

14) Live Vaccines (Live attenuated influenza vaccine, Varicella or Zoster vaccine, Vaccinia (smallpox ACAM-2000), Yellow Fever, Measles*, Typhoid) are contraindicated in persons with severe immunosuppression based on the person's age (ACIP): CD4<750 for those younger than 12 months, <500 for those aged 1-5 years, and <200 for those >6 years old. Expert consultation is recommended for persons under the age of 12 years.

*The MMR vaccine should be given to persons with CD4 ≥200 cells/mm^3 born in or after 1957 who have not received the vaccine or do not have immunity based on laboratory testing.

15) Pregnant persons: COVID-19, TdaP, and inactivated influenza vaccines are recommended for use during pregnancy. Other vaccines are either contraindicated or recommended under certain circumstances or if benefits outweigh risks through shared decision making. For further guidance, see https://www.cdc.gov/vaccines/pregnancy/hcp-toolkit/guidelines.html.

16) Pediatric patients: Expert consultation is recommended for children under the age of 12 years.

17) Booster doses as recommended by CDC guidelines.

D. Treatment:

1) All PWH should receive ART, regardless of CD4 count, to reduce morbidity and mortality, improve health outcomes, and prevent transmission of HIV to others.

2) Treatment should be initiated immediately or as soon as possible after diagnosis.

   a. Same-day treatment should be offered if there are no medical indications to defer therapy (e.g., signs/symptoms of intracranial OI).

   b. If treatment is offered before the results of treatment-naïve genotype are available, an integrase inhibitor-based regimen is recommended.

3) All PWH should be informed that maintaining a plasma HIV RNA (viral load) of <200 copies/mL, including any measurable value below this threshold value, with ART prevents sexual transmission of HIV to their partners. Patients may recognize this concept as Undetectable = Untransmittable or U=U.

4) Guidelines on antiretroviral treatment regimens for patients who are initiating ART can be found at https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/table-7-antiretroviral-regimen?view=full.

5) Guidelines for the management of treatment-experienced patients, including treatment optimization for patients using oral or long-acting injectable medications, can be found at https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/optimizing-antiretroviral-therapy?view=full.

6) For patients with HBV coinfection, as determined by a positive HBsAg or HBV DNA test result, tenofovir disoproxil fumarate or tenofovir alafenamide, plus either emtricitabine or lamivudine, should be used as part of the ART regimen to treat both HBV and HIV.

7) Patients with HCV coinfection should be managed based on the most up-to-date recommendations (http://www.hcvguidelines.org). In general, the goals of therapy, treatment regimen, and monitoring parameters for HIV/HCV-coinfected patients are similar to those

recommended for HCV-monoinfected patients.

E. Prophylaxis

1) Primary and secondary prophylaxis against opportunistic infections, including but not limited to *Pneumocystis jirovecii*, *Toxoplasma gondii*, coccidioidomycosis, histoplasmosis, cystoisosporiasis, and *Mycobacterium avium* complex should be provided if indicated. https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-opportunistic-infections/whats-new
2) Doxycycline STI post-exposure prophylaxis (doxy-PEP) should be offered to cismen and transwomen who have sex with men who have had a bacterial STI in the past twelve months and discussed with others in this population and prescribed if requested. Counseling of ciswomen who are interested in doxy-PEP should include the conflicting evidence to date on doxy-PEP efficacy among ciswomen, including: 1) a large clinical trial that showed no effect of doxy-PEP on STI incidence among ciswomen; 2) the likely contribution of low adherence to this result; and 3) pharmacologic studies that indicate that doxy-PEP should be effective at preventing STI acquisition through receptive vaginal intercourse. https://www.cdc.gov/std/treatment/guidelines-for-doxycycline.htm

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

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

   Primary Care Guidance for Persons with Human Immunodeficiency Virus: 2020 Update by the HIV Medicine Association of the Infectious Diseases Society of America: https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciaa1391/5956736

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

1) Guidelines for Cervical Neoplasia:
   a. Age <21 years: Pap test within one year of sexual activity and no later than age 21
   b. Age 21-29 years: Pap test at time of HIV diagnosis. Repeat yearly for three years. If all tests

are normal, repeat Pap test every three years thereafter.

c. Age <30 years: No HPV testing should be performed unless abnormalities are found on Pap test.

d. Age ≥30 years: Pap only (same as for 21-29 years) or Pap with HPV testing. If both tests are negative, repeat Pap with HPV test every three years thereafter.

e. If three consecutive Pap tests are normal, then a follow-up test should be done every three years.

f. Patients with abnormal Pap smears or a history of an untreated abnormal Pap smear should be referred for colposcopy and should receive same management and follow-up as the general population.
Refer to American College of Obstetrics and Gynecology (ACOG) guidelines for management of abnormal cervical cancer screening results:
https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2020/10/updated-guidelines-for-management-of-cervical-cancer-screening-abnormalities

f. Cervical cancer screening should continue throughout the patient's lifetime and not, as in the general population, end at 65 years of age.

2) Annual mammograms initiated at age 50 or earlier depending on history
3) Treatment for pregnant persons living with HIV – recommend referral to specialist (i.e., UCSD Maternal, Child & Adolescent Program)

H. Anal Cancer Screening – Currently, there are no national screening guidelines for the use of anal Pap tests for cancer screening. However, the Committee endorses guidelines developed by the New York State Department of Health AIDS Institute (https://www.hivguidelines.org/guideline/hiv-anal-cancer/) that recommend annual screening for anal symptoms, visual inspection of the perianal region, education, and digital anorectal examination (DARE) for all PWH aged ≥35 years, regardless of HPV vaccination status. DARE should also be performed for persons <35 years of age who present with signs or symptoms suggestive of anal dysplasia. Further, PWH aged 35 years and older who are at higher risk of having anal dysplasia should have an anal Pap test, with appropriate follow-up (including high-resolution anoscopy) for those with an abnormal anal Pap test result. These recommendations will be revised as needed as new evidence and guidelines become available.

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

1) For guidelines regarding evaluation for and provision of oral and long-acting injectable PrEP, please refer to the U.S. PHS Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – 2021 Update.
https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.pdf
2) For guidelines regarding partner services for PLWH, please refer to the Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection.
https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5709a1.htm

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

K. COVID-19

1) As stated previously, all PWH should receive all recommended COVID-19 vaccines, in addition to vaccines for other respiratory pathogens (e.g., pneumococcus, influenza, RSV) according to ACIP recommendations (see **Section C – Guidelines for Immunization**).
2) All patients should maintain on-hand at least a 30-day (and ideally a 90-day) supply of ART.

3) Telephone and virtual visits for routine non-urgent care should be considered as an option to encourage continuous engagement in care.

Source Documents

1. Clinical Guidelines Home Page (DHHS), accessed on November 8, 2023 https://clinicalinfo.hiv.gov/en/guidelines

2. ACIP Recommendations Home Page, accessed on November 8, 2023 https://clinicalinfo.hiv.gov/en/guidelines

3. San Diego Tuberculosis Risk Assessment, access on November 8, 2023 https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/tuberculosis_control_program/SD_TB Risk Assessment 2018.pdf

4. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV – Laboratory Testing – Laboratory Testing for Initial Assessment and Monitoring of Patients with HIV on Antiretroviral Therapy (DHHS), accessed on April 19, 2021 https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/tests-initial-assessment-and-follow?view=full

5. Recommendations for Providing Quality Sexually Transmitted Diseases Clinical Services, 2020 (CDC), accessed on November 8, 2023 https://www.cdc.gov/mmwr/volumes/68/rr/rr6805a1.htm#:~text=CDC%20organized%20the%20recommendations%20for,STD%20or%20STD-related%20conditions.

6. Sexually Transmitted Infections Treatment Guidelines, 2021 (CDC), accessed on November 8, 2023 https://www.cdc.gov/std/treatment-guidelines/default.htm

7. Update to CDC's Treatment Guidelines for Gonococcal Infection, 2020, accessed on November 8, 2023 https://www.cdc.gov/mmwr/volumes/69/wr/mm6950a6.htm?s_cid=mm6950a6_w

8. California Department of Public Health (CDPH) Dear Colleague Letter: Doxycycline Post-Exposure Prophylaxis (doxy-PEP) for the Prevention of Bacterial Sexually Transmitted Infections (STIs), accessed on November 8, 2023 https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH Document Library/CDPH-Doxy-PEP-Recommendations-for-Prevention-of-STIs.pdf

9. Recommendations for the Laboratory-Based Detection of *Chlamydia trachomatis* and *Neisseria gonorrhoeae* – 2014 (CDC), accessed on November 8, 2023 https://www.cdc.gov/std/laboratory/2014labrec/2014-lab-rec.pdf

10. Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV (DHHS) – Hepatitis B Virus Infection, accessed on November 8, 2023 https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-opportunistic-infections/hepatitis-b-0?view=full

11. Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV (DHHS) – Hepatitis C Virus Infection, accessed on November 8, 2023 https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-opportunistic-infections/hepatitis-c-virus?view=full

12. County of San Diego HHSA HIV Care and Services Resources, accessed on November 8, 2023
https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/hiv_std_hepatitis_branch/HIVAIDSCareandServices/hiv-aids-care-and-services-resources.html#eligibility

13. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV (DHHS) – Laboratory Testing – Plasma HIV-1 RNA (Viral Load) and CD4 Count Monitoring, accessed on November 8, 2023
https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/plasma-hiv-1-rna-cd4-monitoring?view=full

14. Adult Immunization Schedule by Age, Recommendations for Ages 19 Years or Older, United States, 2023 (CDC), accessed on November 9, 2023
https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html

15. Adult Immunization Schedule by Medical Condition and Other Indication, Recommendations for Ages 19 Year or Older, United States, 2023 (CDC), accessed on November 9, 2023
https://www.cdc.gov/vaccines/schedules/hcp/imz/adult-conditions.html

16. Influenza ACIP Vaccine Recommendations (CDC), accessed on November 9, 2023
https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html

17. Human Papillomavirus (HPV) ACIP Vaccine Recommendations (CDC), accessed on November 9, 2023
https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hpv.html

18. Varicella ACIP Vaccine Recommendations (CDC), accessed on November 9, 2023
https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/varicella.html

19. Zoster (Shingles) ACIP Vaccine Recommendations (CDC), accessed on November 9, 2023
https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/shingles.html

20. Hepatitis B ACIP Vaccine Recommendations (CDC), accessed on November 9, 2023
https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hepb.html

21. Hepatitis A ACIP Vaccine Recommendations (CDC), accessed on November 9, 2023
https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hepa.html

22. Pneumococcal ACIP Vaccine Recommendations (CDC), accessed on November 9, 2023
https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/pneumo.html

23. Meningococcal ACIP Vaccine Recommendations (CDC), accessed on November 9, 2023
https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mening.html

24. DTaP/Tdap/Td ACIP Vaccine Recommendations (CDC), accessed on November 9, 2023
https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/dtap.html

25. Orthopoxviruses (Smallpox and Monkeypox) ACIP Vaccine Recommendations (CDC), accessed on November 9, 2023
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APPENDIX A
SAMPLE Sexual Health
Risk Assessment Form

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

1. Have you had sex (oral, vaginal, anal) within the **last 3 months**? □ Yes / □ No / □ Decline
   (If you answered **No please skip to #6**)

2. In the **last 3 months**, how many sexual partners did you have? # _____ Male / # _____ Female / # _____ Transgender

3. How often did you use condoms?
   □ Always (100%) / □ Most of the Time (75% or more) / □ Sometimes (50%) / □ Seldom (25%) / □ Never (0%)

4. In the **last 3 months** how many times have you had sex without using a condom?
   # _____ Oral / #_____ Vaginal / # _____Anal; check one: □ Insertive (top) / □ Receptive (bottom) / □ Both

5. In the **last 3 months** what was the HIV status of your sex partner(s)? (Check all that apply)
   □ Positive / □ Negative / □ Unsure

6. Have you had any of the following symptoms in the **last 3 months**? **Yes** **No**

Discharge from penis/vagina	□	□
Burning feeling with urination	□	□
Sores on your genitals	□	□
Anal discharge or pain	□	□
Mucous or blood in your stool	□	□
Throat sores or pain	□	□
Skin rash	□	□

7. Have you been diagnosed with a sexually transmitted disease (STD, such as Syphilis, Chlamydia, Gonorrhea, NGU, Genital Warts, and Genital Herpes) in the **last 3 months**? (Check one): □ Yes / □ No / □ Don't know
   If you answered yes, did you complete treatment? (Check one): □ Yes / □ No / □ Don't know

8. In the **last 3 months** have you used **non-injection** street drugs 9i.e. marijuana, meth, crystal, speed, glass, crack, ecstasy. cocaine)? □ Yes / □ No

9. Have you **ever injected** steroids, hormones, vitamins or street drugs? □ Yes / □ No
   a. If you answered yes, when was the last time you injected? _____
   b. Did you ever share needles? □ Yes / □ No

10. In the **last 3 months** do you feel that your alcohol or drug use caused you to engage in risky activities (i.e. unprotected sex, needle sharing), even once? □ Yes / □ No

11. Would you be interested in help to inform your sex and/ or needle sharing partner(s) of possible HIV exposure?
    □ Yes / □ No / □ Maybe

If you answered Yes or Maybe and would like to speak to a Counselor, please tell us the best way to contact you:
Phone: _____ Can we leave a confidential message? □ Yes / □ No
Text: _____ Email: _____

Provider/Staff Signature: _____

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