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Management of Human Immunodeficiency Virus Infection/Acquired Immunodeficiency Syndrome	ACA Standards: 4-4357M, 4-4559M, 4-4367, 4-ACRS-4C-10, 4-ACRS-4C-09		
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Management of Human Immunodeficiency Virus Infection/ Acquired Immunodeficiency Syndrome

This guideline is intended to provide general information about the primary care treatment of human immunodeficiency virus infection. This plan will address the management of HIV/AIDS infection and procedures for identification, surveillance, immunization (when applicable), treatment follow-up, and isolation (when Indicated) 4-4357M. Standards for treatment of this disease are evolving rapidly and the guideline upon which this document is based is updated on a frequent basis. When antiretroviral therapy is initiated or changed consultation is required with the chief medical officer, Office of Medical Services/or designee.

I. Identification of HIV infection (4-ACRS-4C-10)

All offenders upon reception and at the offenders request as clinically indicated will receive a serologic test for HIV antibody and pre-test and post-test counseling.

- A. Pre-test counseling may be provided through videotapes, pamphlets, brochures, and fact sheets. Post-test counseling will be conducted on a one-to-one basis with a clinical staff member.
- B. A clinical staff member or a trained HIV counselor will be available to answer the offenders questions concerning HIV during each counseling session.
- C. The goals of HIV counseling will include but will not be limited to:
 - 1. Identify offenders who are unaware, uninformed, misinformed, or in denial of their risk for HIV infection and facilitate an accurate self-perception of the risk.
 - 2. Prepare offenders for and give them information concerning the interpretation of HIV test results, the natural history of HIV infection, it's effects on physical and mental health, the role of health maintenance, and available treatments.
 - 3. Assist offenders in negotiating a relevant risk reduction plan and attempt to secure a commitment from them to reduce their HIV risk.
 - 4. Include patient referrals to the appropriate individuals for psychological support and provide them with encouragement to make desired behavioral changes.
 - 5. Include patient referrals to appropriate drug treatment services for individuals whose substance abuse problems enhance their HIV risk.
 - 6. Include information concerning the increased risk of HIV transmission associated with other sexually transmitted diseases and make patients referrals for additional sexually transmitted diseases examination and treatment.
 - 7. Include patient referrals for high-risk negative offenders who require additional medical, preventive, and psychosocial services.
 - 8. Communicate the importance of the offenders' responsibility to disclose appropriate information concerning notification of past sexual and needle-sharing partners.

II. Surveillance

Both HIV infection and AIDS are reportable diseases in the state of Oklahoma, and are to be reported to the OSDH by telephone (405) 271-4060 or FAX (800) 898-6734 within one business day from diagnosis, utilizing ODH form 295 "Reportable disease Card". In addition, offenders with newly diagnosed HIV/AIDS should be reported to the nurse manager (Infection Control) fax

405.962.6147 at the Office of Medical Services, and logged on the monthly medical Services report.

III. Initial Evaluation

The initial evaluation should determine the presence of opportunistic infections or other complications (i.e. wasting, malignancies, dementia) of HIV infection, either currently or by history. Additionally, a thorough medication history is crucial for making decisions in the event of antiretroviral resistance. Documentation of the chronic illness will be documented in accordance with [OP-140137](#) entitled “Chronic Illness Management” and utilizing the “Chronic Illness Note/Physical Examination” form, ([DOC 140137 A](#)).

A. History

1. HIV risk factors
2. Illnesses – opportunistic infections, tuberculosis, sexually transmitted diseases, malignancies,
3. Medication history – including current and past antiretroviral use
4. Allergies
5. Review of systems
 - a. General – weight loss, fatigue, night sweats, body shape changes
 - b. Skin – rashes, nodules, zoster
 - c. Oral – pain, ulcers, dentition
 - d. GI – dysphagia, diarrhea, hematochezia
 - e. Pulmonary – cough, dyspnea, chest pain
 - f. Genitourinary – dysuria, renal stones
 - g. Neurological – dementia, motor symptoms, focal symptoms

B. Physical Exam

1. Complete set of vital signs (weight, temperature, pulse, respiration, blood pressure).
2. Skin – molluscum, kaposi’s sarcoma, zoster, seborrheic dermatitis
3. Lymph nodes – generalized vs. localized (lymphoma)

4. HEENT – oral candidiasis, leukoplakia, visual acuity, baseline dilated retinal exam, then dilated retinal exam for visual complaints or every 6 months if CD4<50
5. Chest – lung sounds, crackles, consolidation
6. Abdomen – masses, organomegaly
7. GU – pelvic exam, pap smear, anal exam
8. Neurologic – motor exam, mental status
9. Mental health referral

C. Lab and other Diagnostic Tests

Basic metabolic profile, CBC, UA, RPR, PPD baseline, Toxoplasma Ab, CD4, viral load.

Newly diagnosed offenders with no history of treatment will also need a HIV Genotype.

IV. Treatment

Primary treatment of HIV infection is complex and guidelines are changing rapidly. When antiretroviral therapy is initiated or changed consultation is required with the chief medical officer, Office of Medical Services/ or designee.

A. Antiretroviral Medications

1. Indications

- a. CD4<350 - treatment should be initiated.
CD4 350-500 - treatment strongly recommended by 55% of December 1, 2009 DHHS panel.
CD4>500 - 50% of the panel thought treatment to be optional.
- b. Viral load >100,000
- c. Antiretroviral therapy should also be initiated, regardless of CD4 count, in patients with the following conditions: pregnancy, HIV-associated nephropathy, and hepatitis B virus (HBV) coinfection when treatment of HBV is indicated.

- d. Symptomatic HIV infection regardless of CD4 count
 - e. Patients initiating antiretroviral therapy should be willing and able to commit to lifelong treatment and should understand the benefits and risks of therapy and the importance of adherence. Patients may choose to postpone therapy, and providers may elect to defer therapy, based on clinical and/or psychosocial factors on a case-by-case basis.
2. Agents – standard of care is treatment with at least three antiretroviral agents. Monotherapy is contraindicated, and dual therapy is contraindicated. Treatment decisions should take into account patient education, anticipated side effects, pill burden, frequency of dosing, food interactions, and other medications the patient is taking.
- B. Opportunistic Infection Prophylaxis
1. CD4 <200 – Pneumocystis jiroveci pneumonia (PJP) prophylaxis (previously known as pneumocystis carinii-PCP)
 - a. Preferred – Bactrim DS one tablet P.O. daily
 - b. Alternatives – Dapsone, Atovaquone, aerosolized Pentamidine
 2. CD4 <100 – Toxoplasma prophylaxis
 - a. Preferred – Bactrim DS one tablet daily
 - b. Alternatives – Dapsone + Pyrimethamine, Atovaquone
 3. CD4 <50 – Mycobacterium avium-cellulare (MAC) prophylaxis
 - a. Preferred – Azithromycin 1200mg P.O. weekly
 - b. Alternatives – Clarithromycin, Rifabutin
 4. Any CD4 count – patients with a history of infection with PJP, Cytomegalovirus (CMV), MAC, Cryptococcus, Histoplasma, Coccidioides, or Toxoplasma may require lifelong preventive therapy specific to their disease.
 5. Treatment for latent TB infection per current CDC guidelines will be administered to all HIV positive patients with TB skin test results of greater than or equal to 5 mm of induration in accordance to the “2002 USPHS/IDSA Guidelines for the Prevention Of Opportunistic

Infections in Persons Infected with Human Immunodeficiency Virus". Should any revision of these guidelines occur prior to any revision of this, those revised guidelines will be utilized in the interim.

C. Vaccines

1. Influenza (annually)
2. Pneumovax (two doses of the vaccine, separated by five or more years, is recommended for immunocompromised persons).
3. Tetanus (as indicated otherwise)
4. Hepatitis A-B vaccination (If no serologic evidence of Immunity)

V. Goals of therapy

- A. Maximal and durable suppression of viral load (<400). NOTE – Any detectable viral load > 400 in a patient on HAART requires urgent intervention. Contact the chief medical officer, Office of Medical Services for advice.
- B. Restoration of immune function (increasing CD4 count)
- C. Prevention of opportunistic infections
- D. Enhance quality of life
- E. Patient education

VI. Isolation

Isolation is not required for offenders with HIV/AIDS infection. Patients with acute or chronic infection should be counseled on measures for preventing further transmission to others. Standard precautions should be followed.

VII. Routine Follow-Up

Once goals of therapy have been reached and the patient is stable, routine follow-up in chronic clinic should be arranged as follows:

- A. Chronic Clinic Visit
 1. Review medication regimen – adherence, side effects
 2. Interval history – review of symptoms, as above
 3. Exam – skin, mouth, lymph nodes, chest, abdomen, weight

4. Lab – CD4, viral load, (basic metabolic profile, and complete blood count if on antiretrovirals; more frequently if toxicity symptoms occur). **A viral load (HIV-1-RNA) of greater than 400 copies for a patient who is on Highly Active Anti-Retroviral Therapy necessitates immediate consideration of a need for change in therapy. The Chief Medical Officer (or designee) or Infectious Disease Specialty Physician at OU should be contacted for treatment advice and follow-up.**
5. Categorize in accordance with “Severity of Common Chronic Illness” (OP-140137, [Attachment A](#)).

B. Annually

1. Review medication regimen
2. Interval history
3. Complete physical exam
4. Dilated retinal exam
5. PAP smear every 6 months for female inmates
6. Dental exam
7. Fasting Lipid Panel
8. RPR

VII. HIV/AIDS Confidential Case Reporting

- A. The facility’s Infection Control Coordinator or a qualified health care professional shall confidentially maintain a current offender roster for inmates who have HIV confirmed positive test results and all confirmed AIDS cases.
- B. The offender roster will include the following information:
 1. Name
 2. DOC number
 3. Date of positive reactivity to the ELISA and/or Western Blot seriological test
- C. The offender roster will contain the following warning label:

1. This roster of names is confidential and is only available to ODOC correctional officers, probation and parole officers or other employee or employees of the Pardon and Parole Board who has or will have direct contact with an offender when such offender is infected with HIV/AIDS disease, pursuant to 63 O.S. 1-523. Failure to comply with this will result in disciplinary action, including termination, and may also subject the violator to civil liability and criminal prosecution pursuant to 63 O.S. 1-502.2 for failure to protect the privacy of a person named on the roster. Failure to comply with this restriction also violated the Health Insurance Portability and Accountability Act (HIPAA) and may subject the violator to civil monetary and criminal penalties.
 2. This roster will be restricted from unauthorized individuals in accordance with 63 O.S. 1-523.
- D. Offender rosters will be located within the facility head or assistant facility head's office and regional district office. The facility head, assistant facility head, and the deputy / regional director / divisions head will be responsible for maintaining the security and confidentiality of the roster. The facility head or the designee will be responsible for notifying the district office when an offender is released to probation and parole district.
- E. Any authorized employee reviewing the HIV offender roster will document each occurrence in the appropriate logbook. The log book entry must contain the following language with the employee's signature and appropriate date:
- "My signature below signifies that I have read and understand the warning restriction and the facility local procedure concerning the HIV offender Roster."
- E. The facility head will implement local procedures to notify sheriff's deputies taking custody of inmates for the ODOC for any reason that the facility has an HIV/AIDS roster. The deputies may review the roster if they desire to do so but the review must be in accordance with the department's procedures and they must read the warning and sign the log.

VIII. References

OP-140137 entitled, "Chronic Illness Management"

OP-140301 entitled, "Tuberculosis Control Program"

Okla. Statutes 63 O.S. 1-1-502.2, 63 O.S. 1-1-523

Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department

of Health and Human Services. December 1, 2009; 1-161. Available at <http://aidsinfo.nih.gov/contentfiles/lvguidelines/adultandadolescentgl.pdf>. May 10, 2010.

2004 Panel on Clinical Practices for Treatment of HIV Infection Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adolescents and Adults http://www.aidsinfo.nih.gov/guidelines/adult/AA_032304.pdf

2002 USPHS/IDSA Guidelines for the Prevention of Opportunistic Infection in Persons Infected with HIV

IX. Action

The chief medical officer, Office of Medical Services will be responsible for compliance with this procedure.

Any exceptions to this procedure will require prior written approval from the director.

This procedure will be effective as indicated.

Replaced: Medical Services Resource Manual 140137-03 entitled "Management of Human Immunodeficiency Virus Infection/Acquired Immunodeficiency Syndrome" dated March 27, 2012.

Distribution: Office of Medical Services Resource Manual

Referenced Forms	Title	Located In
DOC 140137A	“Chronic Illness Note/Physical Examination”	OP-140137

Attachments

Attachment A	“Severity Classification of Common Chronic Illness”	OP-140137
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