HIV Treatment / Viral Load Suppression (HIV Return to Care Guidelines, 2/23/21)

	Clinicians	Case Managers, Nurses, MAs	Program Staff, Schedulers
A. ESTABLISHED PATIENTS-STABLE			
1. Visits	Virtual visit at least every 3 months, in-person visit at least once a year.	Patients should be supported in attending routine visits.	PCP may deem in-person visit not absolutely necessary.
2. Outreach to Patients without Return Appointments	Clinicians should request a return appointment after every visit.	Staff should outreach those without a return appt. to check on their status and make an appointment.	A registry of HIV patients should identify those without an active return appointment .
3. Labs	Every 3 months, which can be extended to 6 months at the discretion of the PCP.	Counsel patients about the need for frequent routine labs	Where possible, combine labs with other in-person needs to reduce visits to the clinic.
4. COVID-related Counseling			
a. HIV and COVID Infection	Avoid ART (anti-retroviral therapy) substitutions during COVID-19 infection or exposure.	Counsel patients that ART should be continued during any form of COVID-19 management.	
b. Measures to Prevent COVID-19 infection	Clinicians should identify PLWHIV with vulnerabilities for severe COVID-19 disease: elderly, smokers, those with obesity, those with serious co-morbid chronic conditions, and those with poorly controlled or advanced HIV disease.	Counsel such patients to be very scrupulous in their preventive measures, such as masking and social/physical distancing. Counsel those without these risk factors that they are probably not at greater risk of severe COVID-19 disease.	Clinics should model to such patients safe practices with respect to masking, social/physical distancing, and hand hygiene.
c. Acute Symptoms	Prioritize PLWHIV with fever or signs of a lower respiratory tract illness for (COVID-19) diagnostic testing regardless of their viral load status or CD4+ T cell count. (IDSA) Pts. should call the clinic first for instructions.	Such patients should be counselled to present to the clinic with serious acute symptoms, especially fever and cough and other symptoms possibly consistent with COVID-19 infection.	Due to high rates of cardiovascular and lung disease and a high prevalence of smoking, clinics should message to PLWHIV that they should contact the clinic early if they develop fever and cough.

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d. Psychosocial Evaluations	Clinicians should be aware that intimate partner violence and child abuse may be exacerbated by isolation in close quarters. Isolation may exacerbate SUD and mental health issues	Assistance and resources may be indicated, as may additional counseling, virtual or in-person. All adherence support services should continue or even be strengthened during the Pandemic.	Clinic protocols should include evaluating patients for disruptions to their social support systems caused by the Pandemic and Shelter-in-Place: food, housing, transportation, child-care, and support services.
e. Sexual Activity	Standard counseling is to avoid sex with others not living with them during the Pandemic, consistent with social distancing guidelines.	However, for patients who are still engaging in sexual activity with those not living with them, a harm reduction approach is best.	Clinic messaging should encourage patients to engage in the safest sex possible. See SFDPH safer sex tip sheet (control + click) HERE.
5. Other Measures			
a. Vaccinations	Keep Influenza and Pneumococcal vaccinations up to date.	Immunizations may be "bundled" with other in-person needs.	
b. Medications	Provide the maximum number of pills and refills the patient can accommodate, consistent with pt. safety and the patient's insurance.	Encourage mail-order or delivery where available. ADAP now allows for early 90-day refills.	Clinic protocols should include limiting trips to the Pharmacy and encouraging adherence
B. ESTABLISHED PATIENTS – UNSTABLE/HIGH RISK - Same as for Stable Patients except as below:			
1. Visits	Virtual visits at least monthly until viral load suppression and stability achieved, in-person visits prn exams.	In-person CM or nurse visits should be scheduled if in-person adherence support is needed.	Where possible, schedule in-person visits in conjunction with lab visits, nurse visits, or other in-person visits.
2. Labs	At least every 3 months; more frequently as needed.	Patients with adherence or drug resistance concerns should be prioritized for viral load testing.	
C. NEW PATIENTS (BOTH NEW TO CLINIC & ESTABLISHED PATIENTS NEWLY DIAGNOSED)			
1. Visits	Rapid ART is more important than ever to reduce the number of in-person visits needed. Patients newly diagnosed or treatment-naïve should be offered immediate treatment. After at least one in-person visit, then weekly virtual visits until stable.	Initial nurse or CM intake visit can be combined with an initial clinician visit and initial labs. Subsequent visits can be the appropriate combination of clinician, nurse, and CM visits.	Clinic protocols should prioritize patients who have recently initiated ART and are not yet virally suppressed for viral load testing.

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D. SPECIAL POPULATION CONSIDERATIONS			
1. SUD (Substance Use Disorder)	Overdose prevention, in the form of support and Naloxone/Narcan, should be prioritized, as should Buprenorphine use; abrupt discontinuation can lead to relapse, overdose, and death. Patients currently taking buprenorphine should have timely access to refills, and any new patients in need of treatment for opioid use disorder should have treatment initiated in a timely manner.	The stress associated with the pandemic may exacerbate symptoms of SUD. In addition, shelter-in-place may reduce access to drugs and increase the need for treatment. SUD remains a barrier to HIV treatment and adherence. Patients should be counseled to continue recovery and/or harm reduction activities as much as possible.	SUD groups and counselling can continue virtually.
2. PEH (Persons Experiencing Homelessness)	Homelessness can present a major barrier to treatment and adherence. In-person visits may need to be prioritized for PEH, who may not be able to manage telehealth visits.	PEH may require support for safe medication storage, transportation, and a variety of other challenges.	Consider partnerships with specialized PEH programs in order to draw on their expertise and referral networks.
3. Major Mental Health Diagnoses	Mental illness can be a major barrier to adherence and treatment. Patients should be counselled to continue mental health visits, either virtual or in-person, and medications.	Primary care providers and case managers may need to provide additional support for clients who need but decline specialty mental health services. Isolation may exacerbate mental illness, as above	
4. Elderly		An increasing number of PLWHIV are long-term survivors who have aged in place, and may need supportive services associated with the elderly, such as IHSS (in-home supportive services) and transportation services.	

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5. Racial and Ethnic Minorities	Blacks/African Americans, LatinX , Native American, and Asian/Pacific Islander patients are more likely to have health equity issues related to HIV care and screening, as detailed below in the following sections.		
6. Persons Recently Incarcerated		Those recently incarcerated will often have major barriers to treatment and adherence, such as insecure housing, SUD, mental health issues, lack of funds, lack of support, and stigma. Some form of case management and/or specialized post-incarceration programs may be indicated to provide support.	
7. Trans People	Trans people and other sexual minorities are also more likely to have health equity issues related to HIV care, due to persistent societal discrimination and risk of violence.		Consider partnerships with specialized Trans programs in order to draw on their expertise and referral networks.
8. Youth and Adolescents	Youth and adolescents, particularly those of color, who are homeless, and who are LGBTQ, will have both health equity issues and specialized age-related needs that are often best met by programs specifically designed around their needs.		Consider partnerships with specialized youth and adolescent programs in order to draw on their expertise and referral networks.

PrEP - Pre-exposure Prophylaxis (HIV Return to Care Guidelines, 2/23/21)

	Clinicians	Case Managers, Nurses, MAs	Program Staff, Schedulers
A. PATIENTS CURRENTLY ON PrEP:			
1. Visits	Schedule virtual visits every 3 months with labs, with at least one in-person visit every year, unless the PCP decides otherwise.	For adherent PrEP patients who do not have other risk factors for STIs (e.g., multiple sex partners), consider in-person testing every 6 months	Both virtual and in-person visits need to be available, with PCP to decide. Home HIV testing should be available.
2. Support	All existing pt. support activities for adherence, labs, and refills should continue throughout the Pandemic.	Intensify support activities as needed for an individual patient.	Clinic support for PrEP patient support programs should continue or increase during the Pandemic.
B. NEW PrEP PATIENTS:			
1. Routine Start of PrEP	Arrange at least one initial visit with initial labs, preferably in-person or video.	New patients should be counseled as to the visit and lab requirements for PrEP.	Initial visit may be by telephone if the patient is known to be stable and adherent, or if the telephone visit will lead to a video or in-person visit if complex problems are uncovered.
2. Same day Start of PrEP	For new PrEP patients who are potentially exposed to HIV (but do not meet the criteria for PEP), consider getting baseline labs and starting PrEP same day if possible.	Counsel such patients that they can be started on PrEP same day, as an inducement to starting PrEP.	
3. Medications	Consider prescribing a 90-day supply of PrEP medicines (traditionally, 30 days are prescribed at a time).	Assist with mail-order delivery or pharmacy delivery where available.	PEH (persons experiencing homelessness) will require support for safe medication storage options.
4. Acute Symptoms and Exposures	Ask patients to call the clinic with serious acute symptoms consistent with COVID-19 infection, especially fever and cough, and any symptoms consistent with acute HIV infection.	Patients should call the clinic first for instructions. Patients should also call after any known exposure to COVID-19, HIV, or STIs, for appropriate evaluations and testing.	

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C. OUTREACH			
1. In-reach	PCPs should decide with patients if PrEP is appropriate if HIV risk factors are mitigated during Shelter-in-place (e.g., sexual activity). PrEP should be offered to all patients asking for STI screening and to all patients with a STI diagnosis who are HIV negative.	The offer of PrEP should come after appropriate patient education, and only if a contra-indication to PrEP does not exist.	All existing clinic patients with HIV risk factors who are HIV negative should be contacted and offered PrEP, if appropriate.
2. Outreach to New Potential Clients	Clinicians should participate in outreach activities as much as possible.	All staff should engage in outreach when out in the community, whether in person or virtually.	Clinics should outreach to members of their communities who have HIV risk factors and would benefit from PrEP during Shelter-in-place.
3. Minorities and Marginalized Communities	MSM of color have less access to and uptake of PrEP than white MSM; they are a prioritized population for offering PrEP.	All staff should prioritize marginalized communities for offering PrEP through both in-reach and outreach.	Likewise, PEH, trans persons, and people with SUD are relatively under-represented in their use of PrEP and should be prioritized for outreach.
D. DEFERRAL OF PrEP, "PrEP ON DEMAND," PAUSING PrEP, AND PEP (POST-EXPOSURE PROPHYLAXIS)			
1. Deferral of PrEP/"PrEP on Demand"/ Pausing PrEP	"For patients not yet on PrEP who are not potentially exposed during shelter-in-place, consider deferring PrEP start until after." Alternatively, consider PEP (see below) or "PrEP on demand" (before and after sex, only recommended for gay and bisexual cisgender MSM and only if patients are not co-infected with hepatitis B, a contraindication for stopping or intermittent use of PrEP).	Patients may be counselled that PrEP may be paused because of no sexual activity during shelter-in-place, or restarted due to resumption of sexual activity, unless they are co-infected with hepatitis B.	Patient education programs and materials should be in place concerning the role of Hepatitis B in PrEP decision making.
2. PEP (Post-exposure Prophylaxis)	Consider home testing for baseline HIV status, r offering a rapid POC test in clinic and ordering all required labs, including 4th generation screening and HIV viral load.	Inform patients that they can initiate HIV post-exposure prophylaxis (PEP) without a visit to an emergency room or clinic by calling the HIV Warmline **[(888) 448-4911]** or calling the clinic.	Workflows should be in place for qualified patients to receive a prescription for a full course of PEP from on-call providers within 72 hours of exposure.

HIV Screening (HIV Return to Care Guidelines, 2/23/21)

	Clinicians	Case Managers, Nurses, MAs	Program Staff, Schedulers
A. PRINCIPLES			
1. Marginalized Communities	Prioritize marginalized communities for screening and testing.	CMs, MAs, & nurses should make special efforts to make members of marginalized communities feel welcome in the clinic.	Marginalized communities will likely require active outreach and welcoming/supportive services in order to be tested in clinical settings.
B. TESTING/SCREENING STRATEGIES			
1. Opt-Out Testing Strategy	HIV testing does not require specific patient approval.	Educate pts that they must specifically opt out of HIV testing if they do not want it to be part of other routine testing	Develop messaging around the need for HIV screening.
2. Yearly Rescreening	Screen more frequently as needed for known exposures or high-risk activities.	Educate pts. with active risk factors that they should be screened for HIV at least yearly, per guidelines.	Protocols should be in place to schedule yearly re-screening and notify patients.
3. Rapid Testing Results	Consider rapid (ideally point-of-care) HIV, Hep. C antibody & RNA (confirmation of infection), and STI testing.	Rapid testing results are popular with many at-risk communities, such as adolescents and young adults. Encourage such pts. to get them.	Self-collected oral, rectal, and vaginal swabs for gonorrhea and chlamydia tests should be available.
4. Linkage of Testing with Same-Day Treatment	Prescribe same-day treatment when feasible.	Educate at-risk patients about the availability of same-day treatment.	Same day treatment/initiation of the treatment process for HIV, Hepatitis C, and STIs are excellent strategies for promoting testing.
5. In-home Testing	Prescribe in-home testing for appropriate patients.	Educate pts. reluctant to come to clinic re in-home testing.	Provide in-home test kits for HIV and STIs to priority populations.
6. Integrated Sexual Health Testing	Prescribe same-day testing when at-risk patients are in the clinic for other reasons.	Educate pts. about the ability to do same day testing for 5 common and/or serious conditions (HIV, Hepatitis C, syphilis, gonorrhea, chlamydia)	The ability to do same day testing for 5 common and/or serious conditions is a useful promotion tool for marginalized communities to come in to the clinic for screening/testing.

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7. Integration with Other Disease Testing	Order HIV, Hep. C, and STI testing when ordering other routine testing.	Encourage at-risk patients to be screened for HIV, Hep. C, and STIs when getting routine services, such as diabetes and hypertension, TB screening, pregnancy testing, Hepatitis A & B vaccinations, and Corona virus testing.	Integrating HIV, Hepatitis C, and STI screening/testing with other non-sexual health routine testing and services will reduce the stigma experienced by many marginalized communities.
C. OTHER STRATEGIES TO SUPPORT SCREENING			
1. Patient Empowerment	When patients feel empowered to make positive screening decisions themselves, they are more likely to engage in screening and agree to offered screening tests.	CMs & MAs should help educate pts. about the benefits of making positive decisions about screening.	Clinic messaging should support positive screening decisions. Provider education should support making the provider-patient relationship more of a partnership.
2. Reminders	Clinics should appoint and support a clinical champion to support screening services.	Utilize the clinic reminder system to remind at-risk patients when screening tests are due.	Consider a screening reminder program for both providers/staff and patients.
3. Patient Safety	Providers should emphasize to patients that the benefits of screening outweigh the risks.	CMs & MAs should reinforce the safety message with patients.	Clinics should promote their efforts to keep patients safe from the Corona Virus during in-person services, including screening.
4. Outreach		Educate patients that most screening services are free or low-cost to the individual and are offered without regard to immigration status.	Outreach to high-risk communities should reflect the diversity of priority populations and should be developed in collaboration with the affected communities.
5. Partnerships with Community Sites for Testing	Consider virtual testing at sites where at-risk individuals may come.		Clinics should consider offering testing at homeless encampments, food pantries, SROs, syringe access programs, drug/alcohol programs, and trans programs.

STD/STI Screening [Sexually Transmitted Infections] (HIV Return to Care Guidelines, 2/23/21)

	Clinicians	Case Managers, Nurses, MAs	Program Staff, Schedulers
A. PRINCIPLES:			
1. Those with STI Symptoms or Exposures	Those with STI symptoms/exposures should be prioritized for prompt evaluation and same day treatment.	CMs should educate pts. as to the need for prompt evaluation of STI symptoms & exposures.	Same day appointments need to be available.
2. Telehealth	Many patients can be managed by telehealth, as below.	Some pts. will need assistance to use telehealth.	Telehealth options need to be available
B. TREATMENT ISSUES:			
1. Presumptive, Same day Treatment	Use patient history, signs and symptoms to reach a presumptive diagnosis, and treat accordingly, with or without laboratory testing, so that treatment is same day.	Educate patients that many STIs can be treated presumptively and same day, potentially via telehealth.	Same-day appointments need to be available. Point-of-care testing (for HIV, Hepatitis C, syphilis) and home test kits should be available to support same-day treatment.
2. Oral Regimens			
a. Widespread Use	Use oral regimens to treat STIs whenever possible.	Educate pts. that oral regimens can be used for many STIs and are effective.	Common oral antibiotics should be available in the clinic to dispense to patients to improve adherence.
b. Syphilis	“Injectable regimens remain the only treatment for people who are (or can become) pregnant and are infected with, or have been sexually exposed to, syphilis.”	Educate women of reproductive age about the need for injectable regimens for potential syphilis.	Appropriate injectable drugs should be available in the clinic for same day administration.
c. Gonorrhea	Standard gonorrhea treatment includes injection.	Counsel patients to seek remote consultation again if symptoms do not resolve as expected after treatment.	
3. Expedited Partner Therapy	Clinicians may provide expedited partner therapy for gonorrhea, chlamydia, and trichomonas.	Educate pts. about the need for partner therapy & the shared clinical decision-making model between clinician & patient.	

	Clinicians	Case Managers, Nurses, MAs	Program Staff, Schedulers
4. Follow-up STI Testing	At the time of treatment for STIs, follow-up STI testing should be recommended.	Educate pts about the rationale, both to ensure successful treatment and to continue STI screening in high-risk individuals.	Follow-up appts. for STI testing need to be available.
C. STI SCREENING OF PLWHIV, PrEP PATIENTS, AND OTHER HIGH-RISK PATIENTS			
1. Routine questions	Patients at higher risk of STIs should routinely be asked about STI symptoms, such as dysuria, anogenital discomfort, ulcers, rashes, and discharges. For high-risk patients, consider STI screening every 3 months, more frequently as needed for high-risk activities and/or frequent calls and drop-ins for potential STIs. Such patients should be considered for STI screening if they come to the clinic for other reasons.	High risk patients should also be counselled that they may have asymptomatic STIs that they could transmit to others, reinforcing the need for STI screening. Several common infections are frequently asymptomatic, including gonorrhea, chlamydia, HIV, syphilis, and Hepatitis B and C.	High risk patients include people living with HIV, PrEP and PEP patients, MSM, young women, young people of color, trans people, persons experiencing homelessness, people who inject drugs, and those recently incarcerated.