Service Standards for Care

Outpatient/Ambulatory Medical Care Services

Table of Contents

Introduction

Standards of Care represent the minimum requirements that programs are expected to meet when providing HIV/AIDS care and support services. These standards are intended to help agencies meet the needs of their clients. These standards do not address all aspects of care but focus on some salient factors. Providers may exceed these standards.

Background

The Ryan White CARE Act Part A provides emergency assistance to Eligible Metropolitan Areas (EMAs) most severely affected by the HIV/AIDS epidemic. The CARE Act stipulates that Part A funds should be used to provide access to integrated health services for persons living with HIV/AIDS (PLWHA) who:

Reside within a designated EMA; and
Have no third party payment source (uninsured);
Have limited third party coverage (underinsured); or
Have been denied coverage by a third party payer (uninsured or underinsured).

CARE funds will be used only for services that are not reimbursed by any other source of revenue. The District of Columbia HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA) and the Care Strategies Sub-Committee of the District of Columbia EMA HIV Health Services Planning Council are developing standards of care for all core medical Ryan White Part A funded HIV health services in the District of Columbia EMA. These standards are designed to define the minimally acceptable levels of service delivery and provide suggested documentation for recording whether service standards are being met.

Service Specific Standards

In addition to the Universal Standards of Care, providers must also meet additional standards that are specific to the particular services they provide. The following section contains standards of care specific to the medical care of HIV clients delivered in the outpatient/ambulatory medical care setting. Some of the information within these standards was adapted from the *New York Department of Health AIDS Institute Primary Care Approach to the HIV-infected client*.

1. Outpatient /Ambulatory Medical Care

Outpatient/ambulatory medical care includes the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. These standards are for the delivery of primary medical care in this setting. Primary medical care is the provision of HIV care and treatment services consistent with the most recent United States Public Health Service (USPHS) guidelines and provided in the context of an ongoing relationship with a personal provider who has comprehensive knowledge of the client's medical conditions; facilitates linkages to and provides information to sub-specialists or other services involved in the care of the client and actively participates in coordinating care with other qualified professionals.

Goals

These minimally acceptable standards for service delivery provide guidance to programs so that they are best equipped to achieve the goals of HIV primary care services, which are to:

- Provide eligible clients with quality health care to slow or prevent HIV disease progression and reduce HIV related mortality rates through medical care that follows the standards of the USPHS guidelines.
- Ensure that the co-morbidities that affect HIV-positive clients are addressed by providing or linking them to services such as medical case management, sub-specialty medical services, substance abuse, mental health and routine age and gender appropriate screenings and services.
- Retain clients in HIV/AIDS primary medical care; promote their adherence to treatment and care and re-engage those who become lost to care all with the purpose of improving health outcomes.

General Recommendations

- To ensure the quality of care, primary care and HIV care should be delivered in the same place. If this cannot be done, the overall health care of clients with HIV infection must be carefully managed to maximize health outcomes. Given the improved survival among persons living with HIV infection, and studies that suggest those living with HIV are at higher risk for developing common health problems, the provider must monitor HIV positive clients for all relevant age and gender specific health problems, and referred for appropriate testing and/or treatment as needed.

- The standards do not dictate whether HIV-infected clients should receive their care from a specialist or a generalist. The emphasis is the importance of the primary care needs of persons with HIV infection and that clients have better outcomes when they receive their care from experienced HIV care providers. The **HIV Medical Association** and the **American Academy of HIV Medicine** provide guidelines for what is considered an experienced HIV care provider.

- The medical home model of care is recommended, in which a multidisciplinary team of health providers with specific roles coordinates a comprehensive, personalized, client-centered approach.

- It is the responsibility of the provider to implement strategies to retain clients in care, re-engage clients who have been out of care and to ensure that all efforts translate into improved health outcomes for the client.

- Every agency that provides HIV medical services must implement an HIV Quality Management Program. The HIV quality management program should be actively

supported and guided by the formal clinical leadership and senior administration, and appropriate resources should be committed to support quality improvement activities. Program staff should be aware of the quality management infrastructure and understand their role in quality improvement activities.

    - Each HIV quality management program must have a written annual quality management plan that is reviewed and updated routinely by its quality management committee.

- Program activities must be informed by consumer input and feedback. Consumers may identify additional concerns and issues for improvement of HIV care.

Standards

These standards are designed to ensure consistency among Part A services provided as part of the District of Columbia's EMA continuum of care for PLWHA. They are not intended to promote a "cookbook" approach to the treatment and care of PLWHA. As stated, these are minimum standards for the provision of these services. Agencies and individuals may exceed these standards. These standards do not supersede but complement the USPHS guidelines.

The following aspects are highlighted in this document:

- Comprehensive medical history
- Health promotion and Psychosocial Assessments
- Coordination and Linkage to services

In these standards, when the term *"clinically indicated"* is used, it refers to the need to perform tests and/or examinations that could have clinically relevant benefits for the particular health outcome, could assess response to therapy or address a symptom or functional problem. The provider must clearly document the clinical rationale that governs the decision for performing the examination or test.

Standard 1.0: Comprehensive Medical History

- Providers must ensure clients undergo triage at intake to determine if urgent or emergent care is needed and then treat as appropriate.
- Providers should try to obtain and document efforts to obtain medical records from past medical providers. These records must include documentation of HIV infection confirmed by serum Western Blot.
- Providers must elicit a complete and comprehensive medical history at baseline within two visits or four weeks, whichever comes first.

Highlighted Elements of the Comprehensive History	
General History	Review sources of past medical care; obtain medical records whenever possible Past hospitalizations, past and current illnesses Family History Tuberculosis history Possible recent exposure to tuberculosis History of positive TST (TB skin test, commonly known as PPD), TB disease, or treatment of latent TB infection History of hepatitis, if known Current prescription and non-prescription medicines, including complementary and alternative medicines and hormones Vaccination history Reproductive history, including pregnancies, births, termination of pregnancy; current contraceptive use and needs Transfusion or blood product history, especially before 1985 Allergies Travel history/place of birth Occupational history and hobbies Pets/animal exposures
HIV treatment and Staging	HIV exposure history Date and place of the diagnosis Route of exposure, if known Most recent viral load and CD4 count Nadir CD4 and peak viral load Drug-resistance testing Current and previous ARV regimens and date of initiation of ARV therapy Previous adverse ARV drug reactions Opportunistic infections Previous adverse reactions to drugs used for OI prophylaxis Providers who have been involved in the client's HIV treatment Client's understanding of HIV disease and treatment

Highlighted Elements of the Comprehensive History	
Mental Health	Mental health diagnoses Psychotropic medications Past psychiatric hospitalizations History of treatment and barriers to treatment Contact information for mental health providers if applicable
Substance Abuse	Types of drugs; past and current use Street drugs—marijuana, cocaine, heroin, methamphetamine, 3,4-Methylenedioxymethamphetamine (MDMA)/ecstasy Illicit use of prescription drugs Alcohol Tobacco Frequency of use and usual route of administration Risk behaviors—drug/needle sharing, exchanging sex for drugs, sexual risk-taking while under the influence of drugs or alcohol History of treatment and barriers to treatment Contact information for substance abuse treatment providers if applicable
Sexual History	Current sexual activity History of sexually transmitted infections Sexual practices—vaginal, anal, oral Gender identity Risk behavior assessment, including use of latex or polyurethane barriers, number of partners
Information for Partner Notification	At the initial visit ask if all sex and needle-sharing partners have been informed of their exposure to HIV. At routine follow-up visits ask if client has any new sex or needle-sharing partners who have not been informed of their exposure to HIV. Elicit partner names and contact information. Submit information to Partner Counseling and Referral Services (PCRS) of the health department to arrange for the notification and HIV testing of the exposed partners.

Highlighted Elements of the Comprehensive History	
Psychosocial Assessment	Housing status Employment and insurance status Educational level Family and partner contacts Stability of personal relationships Domestic violence screening Legal Issues Living will and health care proxy Permanency planning for dependent children (for clients with severely advanced disease)
Review of Systems	Constitutional, Head/Eyes/Ears/Nose/Throat, Pulmonary, Cardiac, Abdominal, Genitourinary, Obstetrics and Gynecological, Musculoskeletal, Neurologic

Standard 2.0: Comprehensive Physical Examination

- Providers must perform a baseline and annual comprehensive physical examination, with particular attention to areas potentially affected by HIV. The comprehensive physical exam should address all systems, must include measurement of all vital signs and must be completed within two visits or one month, whichever comes first.

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

- Providers must refer women with cervical high grade cervical squamous intraepithelial lesions (hsil) and any client 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 colposcopy and anoscopy respectively and/or examination with biopsy of abnormal tissue and for subsequent treatment if indicated.

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

- Providers must perform a comprehensive substance abuse and mental health assessment at baseline and at least annually. Providers must incorporate selected brief screening instruments such as the Client Diagnostic Questionnaire (CDQ) into the

assessment process for both categories. The chosen screening instruments should be approved by DOH/ HAHSTA and tailored for optimal use at initial, annual, and as needed for interim visits and adjusted for the client's mental health or substance use history.

Standard 3.0: Routine Laboratory and Diagnostic Assessments

- Providers must order appropriate laboratory assessments and screening tests for management of HIV-infected clients according to USPHS guidelines. All clinical and immunological monitoring should be followed according to the most up to date guidelines as published in the USPHS guidelines available on the web at **http://aidsinfo.nih.gov/Guidelines/**

Routine Laboratory and Diagnostic Assessments		
Assessment	Diagnostic Screen	Frequency
Basic laboratory assessments	Complete metabolic panel and complete blood count	Baseline and every 3 to 6 months or as clinically indicated.
Immunologic Assessment	CD4 count	Baseline and every 3 months to 6 months.
Virological Assessment	Quantitative HIV RNA testing for viral load assessment. ***For guidance on resistance testing please refer to the Guidelines for the Use of Antiretroviral agents in HIV-1 infected Adults and Adolescents at http://aidsinfo.nih.gov***	Baseline and every 3 to 6 months.
Hepatic Assessment	Hepatitis A, B and C serology	Baseline and periodic assessment as clinically indicated.
Metabolic assessment	Fasting Lipid panel including cholesterol	Baseline and annually.

Routine Laboratory and Diagnostic Assessments		
Assessment	Diagnostic Screen	Frequency
Nutritional assessment	A nutrition assessment is an in-depth evaluation of both objective and subjective data related to an individual's food and nutrient intake, lifestyle, and medical history. The assessment leads to a plan of care, or intervention, designed to help the individual either maintain the assessed status or attain a healthier status.	Baseline and periodic assessment as clinically indicated.
Tuberculosis evaluation	Providers must obtain a TST (tuberculin skin test, commonly known as PPD) or other FDA-approved test for clients with no previous documented history of TB or no previous positive TST Chest x-ray for clients known to have a history of TB or known to be TST positive or suspected to be anergic. After active tuberculosis has been excluded, Providers must 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.	Baseline and annually.
Screening for sexually transmitted infections	RPR or VDRL for syphilis with verification of positive test by confirmatory FTA-Abs or TP-PA Gonorrhea and Chlamydia NAAT or probe	Baseline and as clinically indicated; every 3 months for those clients with continued high-risk behavior

Routine Laboratory and Diagnostic Assessments		
Assessment	Diagnostic Screen	Frequency
Cytologic Screening	Cervical pap tests	Baseline, 6 months after baseline and then annually as long as results are normal
	Anal pap tests *(these are strongly recommended but not yet mandatory*)	Baseline for every client with a history of receptive anal intercourse (regardless of gender or sexual orientation) and for every male client with a history of anal warts(regardless of sexual orientation) and every female with a history of anogenital warts and/or cervical dysplasia. If the results are normal, the PAP smear should be repeated in six months. If the second PAP smear is still negative, then repeat annually. Any abnormality in the PAP smears is an indication for referral for high resolution anoscopy and biopsy of suspected areas.

Standard 4.0: Antiretroviral Treatment, Prevention and Treatment of Opportunistic Infections and Vaccines

- For antiretroviral (ARV) treatment considerations, please refer to the **Guidelines for the use of Antiretroviral Agents in Adults and Adolescents**, 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 at http://aidsinfo.nih.gov

- For the diagnosis, prevention and treatment of Opportunistic Infections please refer to the **Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-infected Adults and Adolescents** at http://aidsinfo.nih.gov.

- For vaccination schedules for HIV positive clients, please refer to the **Recommended schedules for HIV positive adults** at **http://www.aidsinfo.nih.gov/contentfiles/Recommended_Immunizations_FS_en.pdf**

Pathogen	CD4 guided initiation of Primary Prophylaxis
Pneumocystis jirovecii pneumonia	CD4 <200 cells/mm^3 or <14%
Mycobacterium avium complex (MAC)	CD4 <50 cells/mm^3
Toxoplasma encephalitis (TE)	CD4 <100 cells/mm^3 and Positive serology for *Toxoplasma* (IgG+)

Standard 5.0: Health Promotion and Psychosocial Assessments

The adoption of healthy living and reduction in risk behaviors among HIV-positive people leads to a substantial improvement in the quality of life and a reduction in HIV transmission rates.

It is understood that information alone, especially on subjects such as sexual activity and drug use, cannot be expected to change clients' behavior. However providers can play a key role in helping clients to understand the transmission risk of certain types of behavior and help clients establish and maintain safer practices, safe disclosure practices and begin personal prevention strategies for themselves and their partners.

- Providers must educate the client about HIV. This must include the natural history of HIV disease; goals of HIV disease management; principles of HIV treatment; side effects of medication and self-monitoring for commonly encountered symptoms.

- Providers must provide or link clients to routine HIV risk reduction counseling, treatment adherence, and behavioral health counseling.

- Providers, at each visit with an HIV-positive person, must include screening for high-risk behavior, discussion of safer sexual practices and link to support for addressing these behaviors.

- Providers must not prevent a client who is actively abusing substances from obtaining access to HIV treatment even if the client is not participating in substance abuse treatment.

Some clients may require more intensive interventions than can feasibly be provided in provider visits. Many have underlying problems that impede adoption of safer behaviors and achieving behavioral change is often dependent on addressing these concerns. It is

imperative that the provider links the client to needed services.

Health Promotion and Psychosocial Assessments		
Topic	Standard	Documentation
Disclosure for Social Support • Those who do not disclose for social support have poorer health outcomes than those who do.	Providers must routinely discuss with clients the importance of disclosure for social support and encourage safe disclosure.	Documentation in client record that these elements have been addressed or are in process.
Mental Health	Providers must routinely inquire about mental health needs in a culturally appropriate and sensitive manner and link clients to services as needed. Providers must use appropriate screening tools (such as the CDQ or other DOH/HAHSTA approved tools) when performing assessments which should be done at baseline and annually.	
Substance Abuse • Substance abuse can cause serious health risks for many including poor adherence to medications and increased disease progression. Under the influence of substances individuals may be more likely to engage in risky behaviors.	Providers must routinely inquire about substance abuse and link clients to services as needed. Providers must use appropriate screening tools (such as the CDQ or other DOH/HAHSTA approved tools) when performing assessments which should be done at baseline and annually.	
Treatment Adherence • This is adherence to both a comprehensive care program and an antiretroviral medication regimen. Several factors can interfere with treatment adherence, thus providers need to be knowledgeable and assist patients in addressing them routinely throughout treatment.	Providers must assess and encourage adherence to both medication and care at each visit. Providers must provide adherence support or link clients to treatment adherence services as clinically indicated. Providers must regularly exchange information with client's treatment adherence counselor and medical case manager.	Documentation in client record that these elements have been addressed or are in process.

Health Promotion and Psychosocial Assessments		
Topic	Standard	Documentation
General prevention	Providers must emphasize that transmission of HIV may occur during unprotected sex, even when clients have undetectable HIV plasma viral loads. Providers must 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. Providers must instruct clients in the proper use of condoms, dental dams, and other barriers to reduce the risk of HIV transmission.	
Tobacco Use • Smoking increases risk of thrush, coronary artery disease and bacterial pneumonias. It has been found to reduce the effectiveness of ARV treatment in women,. HIV infection further increases the risk of lung and other cancers associated with smoking.	Providers must assess smoking status and should encourage those who smoke to stop. Linkages to smoking cessation programs and pharmacotherapy should be provided if the client is interested.	
Domestic Violence	Providers must screen for domestic violence in a culturally sensitive approach. Providers must screen all male and female clients for current and lifetime domestic violence (both as victims and as perpetrators) at baseline and annually.	

Standard 6.0: Problem List, Medical Treatment Plan and Progress Notes

- Providers must develop and document a problem or needs list with information gathered from the comprehensive medical history, physical examination, and laboratory and diagnostic testing. The list should be made with the involvement of the client, prioritizing those of greatest importance to the client. As problems or needs are resolved, the list should be updated.

- Providers must develop a medical treatment plan. This outlines time-specific measurable goals, interventions, medications and/or specialty care referrals prescribed to address the problems/needs identified on the list. The client should have a central role in making decisions regarding the plan, but only the provider must sign the plan. Documentation in the client's chart must reflect the client's participation and agreement with the medical plan.

- Providers must document a client's clinical status and achievements during the course of care within progress notes. At least one progress note must be generated for each client encounter. It must be readable, easily understood, complete, accurate and concise.

- Providers must maintain an updated list all medications with appropriate dosages, frequency and routes administration for each client that is verified with the client at every visit.

Standard 7.0: Coordination of Care and Linkage to Services

As part of the client's treatment plan, services outside of the primary care provider's agency maybe necessary. The provider is responsible for ensuring that the client is linked to these services and the clients care is coordinated. The services may include specialty medical care, mental health treatment, medical case management, substance use prevention and treatment, housing and social support services.

- Providers must ensure that linkages include a defined process for information exchange and feedback and a mutually understood method between referrer and referee for enrolling clients in services.

- Providers must actively participate in the coordination of services for their clients. This must include the continuous interchange and exchange of client treatment information between the clients designated primary medical care provider and external service providers.

- Providers must create linkages and/or referrals that match the client's self-identified priorities, as these are more likely to be completed; the services need to be responsive to the client's needs and appropriate for the client's culture, language, gender identity and expression, sexual orientation, age, and developmental level.

- Providers must use medical case management as appropriate to enhance the coordination of care provided by agencies such as home care, nutrition services, and nursing services and to prevent duplication of services. Providers must regularly involve medical case managers in case reviews and conferences to discuss all issues that may affect a client's ability to adhere to care.

    - A critical support in the coordination of care is the client's medical case manager. Emphasized in both the Health and Human Resources Administration (HRSA) definition of

medical case management *(http://hab.hrsa.gov/publications/november2008/)* and DOH/HAHSTA medical case management guidelines is that HIV/AIDS medical case management services focus on 1) retention in medical care and 2) achieving positive health outcomes for clients, particularly the importance of viral load suppression for those on antiretroviral treatment.

- Providers must ensure comprehensive care for clients either by providing all services or linking them to essential services for good health and outcomes. From the following table guidance can be obtained to address medical co-morbidities and routine age and gender specific care.

Resource guide for care of HIV positive clients

Resource guide for different aspects of care of HIV positive persons			
Topic	Title	URL	Issuing Agency
ARV in Adults and Adolescents	Guidelines for the use of Antiretroviral Agents in HIV-infected and	http://aidsinfo.nih.gov/guidelines	DHHS
ARV in Children	Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection	http://aidsinfo.nih.gov/guidelines	DHHS
Immunization Schedules	Practical Guidelines for Quality Standards for Immunization	http://www.cdc.gov/vaccines/pubs/ACIP-list.htm#comp	Advisory Committee on Immunization Practices
Mental Health	Mental Health Care for People with HIV infection; Clinical Guidelines for the Primary Care Practitioner	http://www.hivguidelines.org/Content.aspx?PageID=261	New York State Department of Health's AIDS Institute
Mental Health and Substance Abuse Assessment	Client Diagnostic Questionnaire	http://hab.hrsa.gov/tools/topics/cdq.htm	Columbia University *(as part of HRSA/HAB's Special Projects of National Significance)*
Metabolic Complications in HIV	Management of Metabolic Complications associated with ART for HIV-1 infection	http://www.iasusa.org/pub/Schambelan%20et%20al-JAIDS-11.102.pdf	IAS USA panel

Resource guide for different aspects of care of HIV positive persons			
Topic	Title	URL	Issuing Agency
HIV Primary Care	Primary Care Guidelines for the Management of Persons Infected with Human Immunodeficiency Virus: 2009 Update by the	http://www.journals.uchicago.edu/doi/abs/10.1086/605292	HIV Medicine Association of the Infectious Diseases Society of America
Resistance Testing	Antiretroviral Drug Resistance Testing in Adults infected with HIV-1	http://www.iasusa.org/pub	IAS USA panel
Hyperlipidemia in HIV	Guidelines for the evaluation and management of dyslipidemia in HIV infected adults receiving ART	http://www.journals.uchicago.edu/doi/abs/10.1086/378131	HIVMA/IDSA; ACTG
Hyperlipidemia	Management of Hyperlipidemia	http://www.americanheart.org	American Heart Association
Diabetes	Clinical Practice Recommendations	http://care.diabetesjournals.org/content/vol31/Supplement_1/index.shtml	American Diabetes Association
Chronic Kidney Disease	Guidelines for the management of Chronic Kidney Disease in HIV-infected clients	http://www.journals.uchicago.edu/doi/abs/10.1086/430257	HIVMA of IDSA
Geriatric	The Graying of an Epidemic	http://www.hivandhepatitis.com/cme/main.html	HIVandHepatitis.com
Hepatitis	Care of HIV clients with Chronic Hepatitis C	n/a	Hepatitis C Virus-HIV International Panel
Hepatitis	Guidelines for the Clinical management and Treatment of Chronic Hepatitis B and C co-infection in HIV infected Adults	http://www.europeanaidsclinicalsociety.org/guidelinespdf/3_Treatment_chronic_hepatitis_coinfection.pdf	European AIDS Clinical Society

Resource guide for different aspects of care of HIV positive persons			
Topic	Title	URL	Issuing Agency
Opportunistic Infections	Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents	http://www.aidsinfo.nih.gov/Guidelines/GuidelineDetail.aspx?MenuItem=Guidelines&Search=Off&GuidelineID=211&ClassID=4	DHHS
Post-Exposure Prophylaxis	Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Post exposure Prophylaxis	http://aidsinfo.nih.gov/guidelines	DHHS
Post-Exposure Prophylaxis	Management of Possible Sexual, Injection-Drug-Use, or Other Nonoccupational Exposure to HIV, Including Considerations Related to Antiretroviral Therapy	http://aidsinfo.nih.gov/guidelines	DHHS
Pregnant women and prevention of perinatal transmission	Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States	http://www.aidsinfo.nih.gov/Guidelines/GuidelineDetail.aspx?MenuItem=Guidelines&Search=Off&GuidelineID=9&ClassID=2	DHHS
Risk Assessment	Incorporating HIV Prevention into the Medical care of persons living with HIV	http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5212a1.htm	CDC, HRSA, NIH, IDSA, HIVMA
Resistance Testing	Antiretroviral Drug Resistance Testing in Adults infected with HIV-1	www.iasusa.org/pub/	International AIDS Society USA Panel
Sexually Transmitted Diseases	Sexually Transmitted Diseases Treatment Guidelines	http://www.cdc.gov/std/treatment/2006/rr5511.pdf	CDC

Resource guide for different aspects of care of HIV positive persons			
Topic	Title	URL	Issuing Agency
Smoking Cessation	Smoking cessation in HIV-infected clients	http://www.surgeongeneral.gov/tobacco/	DHHS
Testing for HIV	Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings- September 22, 2006	http://www.aidsinfo.nih.gov/Guidelines/GuidelineDetail.aspx?MenuItem=Guidelines&Search=Off&GuidelineID=16&ClassID=5	DHHS
Transgender Health	Challenges associated with care to male to female transgender persons	http://www.nmaetc.org/resources/docs/Final_DC_talk_on_Transgender.pdf	NMAETC
Women	A Guide to the Clinical Care of Women with HIV	http://hab.hrsa.gov/publications/womencare05/	DHHS/HRSA