HIV/AIDS – Kentucky

Course Description
“HIV/AIDS – Kentucky” is a home study continuing education course for Kentucky licensed physical therapists, physical therapist assistants, and other healthcare professionals. This course presents current information about HIV/AIDS including sections on Basic Medical and Epidemiological Information, Methods of Transmission, Prevention, and Treatment, Management of HIV in the Healthcare Workplace, Legal Issues Surrounding HIV Infection, Appropriate Attitudes & Behaviors, and Comprehensive Human Services Available.

Course Rationale
This course was designed to meet the requirements of The Kentucky Revised Statutes (KRS) 214.610, 214.615, and 214.620.

Course Objectives
After completing the continuing education program, the therapist/assistant will be able to:
   1. Understand the scope and impact of HIV/AIDS worldwide.
   2. Identify and differentiate the transmission modes of HIV infection
   3. List the signs and symptoms of HIV infection and AIDS
   4. Identify and differentiate between commonly used screening and confirmatory tests
   5. Recognize current treatment recommendations for HIV infection
   6. Recognize current prevention and treatment strategies for opportunistic infections
   7. Recognize and understand key social intervention strategies
   8. Identify management strategies relating to HIV in the healthcare workplace
   9. Identify available resources for additional HIV/AIDS information
  10. Understand and apply all of the laws and statutes that pertain to the rights of individuals with HIV/AIDS, and to their care and treatment.

Course Instructor
Michael Niss, DPT

Method of Instruction
Text-based online home study course

Target Audience
Kentucky licensed physical therapists, physical therapist assistants, and other healthcare professionals

Course Educational Level
This course is applicable for introductory learners.

Course Prerequisites
None

Continuing Education Credits
Two (2) hours of continuing education credit

Criteria for issuance of Continuing Education Credits
A documented score of 70% or greater on the written post-test.

Determination of Continuing Education Credits
HIV/AIDS – Kentucky will require at least 2 hours to complete. This estimate is based on the accepted standard for home based self-study courses of approximately 10-12 pages per hour. The complete text of this course is 28 pages (excluding References and Post Test)
HIV/AIDS – Kentucky

Outline

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Course Goals &amp; Objectives</td>
<td>1</td>
</tr>
<tr>
<td><strong>Course Outline</strong></td>
<td>2</td>
</tr>
<tr>
<td><strong>Basic Medical and Epidemiological Information</strong></td>
<td>3-10</td>
</tr>
<tr>
<td>Basic Medical Information About HIV</td>
<td>3</td>
</tr>
<tr>
<td>Acquired Immune Deficiency Syndrome (AIDS)</td>
<td>3</td>
</tr>
<tr>
<td>How HIV Affects the Immune System</td>
<td>3-4</td>
</tr>
<tr>
<td>Current HIV/AIDS Epidemiology</td>
<td>4</td>
</tr>
<tr>
<td>Identified Risk Behaviors</td>
<td>4-5</td>
</tr>
<tr>
<td>Opportunistic Diseases that define AIDS</td>
<td>5-6</td>
</tr>
<tr>
<td>Oral Manifestations of HIV/AIDS</td>
<td>6</td>
</tr>
<tr>
<td>Tests Used to Diagnose HIV Infection</td>
<td>6-8</td>
</tr>
<tr>
<td>CDC’s Opt-Out Testing Recommendations</td>
<td>8-10</td>
</tr>
<tr>
<td><strong>Methods of Transmission, Prevention, and Treatment of HIV</strong></td>
<td>10-16</td>
</tr>
<tr>
<td>Methods of Transmission</td>
<td>10-13</td>
</tr>
<tr>
<td>Methods of Prevention</td>
<td>13-14</td>
</tr>
<tr>
<td>Perinatal Transmission and Prevention</td>
<td>14-15</td>
</tr>
<tr>
<td>Current Medical Treatment for HIV Infection</td>
<td>15-16</td>
</tr>
<tr>
<td><strong>Management of HIV in the Healthcare Workplace</strong></td>
<td>16-18</td>
</tr>
<tr>
<td>OSHA Bloodborne Pathogens Standards</td>
<td>16-18</td>
</tr>
<tr>
<td>HIV Post Exposure Prophylaxis</td>
<td>18</td>
</tr>
<tr>
<td><strong>Legal Issues Surrounding HIV Infection</strong></td>
<td>19-22</td>
</tr>
<tr>
<td>Consent to Test</td>
<td>19</td>
</tr>
<tr>
<td>Confidentiality Issues</td>
<td>19-20</td>
</tr>
<tr>
<td>KY HIV/AIDS Reporting Requirements</td>
<td>20-21</td>
</tr>
<tr>
<td>Americans with Disabilities Act</td>
<td>21-22</td>
</tr>
<tr>
<td><strong>Appropriate Attitudes &amp; Behaviors</strong></td>
<td>22-24</td>
</tr>
<tr>
<td>Stigma</td>
<td>22</td>
</tr>
<tr>
<td>Cultural Sensitivity of the Caregiver</td>
<td>22</td>
</tr>
<tr>
<td>Mode of Infection is Not the Issue</td>
<td>22-23</td>
</tr>
<tr>
<td>Caregivers’ Prejudices</td>
<td>23</td>
</tr>
<tr>
<td>“Golden Rule” Approach</td>
<td>24</td>
</tr>
<tr>
<td><strong>Comprehensive Human Services Available</strong></td>
<td>24-28</td>
</tr>
<tr>
<td>Kentucky's Ryan White &amp; state funded services programs</td>
<td>24-25</td>
</tr>
<tr>
<td>Community-Based Organizations</td>
<td>25-28</td>
</tr>
<tr>
<td><strong>References</strong></td>
<td>28</td>
</tr>
<tr>
<td><strong>Post-Test</strong></td>
<td>29-30</td>
</tr>
</tbody>
</table>

Innovative Educational Services
To take the post-test for CE credit, go to: www.cheapceus.com
Basic Medical and Epidemiological Information

Basic Medical Information About HIV

HIV is a member of a group of viruses called retroviruses. A retrovirus is a virus that changes itself very rapidly. One reason why HIV is a particularly serious infection is that it attacks and destroys cells of the immune system—called T-cells or CD4 cells—that are designed to fight infections and diseases. After HIV penetrates these cells, it reprograms the cell so that it begins to produce many copies of the virus. Eventually, HIV destroys the immune cells. Another reason why HIV is a very serious infection is that it has the ability to mutate rapidly. This makes it especially difficult for researchers to find an effective treatment or vaccine.

There are two types of HIV. HIV-1 is responsible for the vast majority of infection and cases of AIDS in the world. HIV-2 is the more common type in West Africa and has a slower course than HIV-1.

From the time a person is infected with HIV, the virus begins to damage the immune system. Although an infected person’s immune system struggles to fight back—and can do so for as many as 10 years or more in an otherwise healthy adult—the virus continues to destroy these defenses until the immune system is too weak to fight off infections.

A person can be infected with HIV and not know it, because any symptoms or illnesses related to HIV may not occur for many years after infection. Most people lead healthy and productive lives after HIV infection—in fact, many people are not aware they are infected because they feel fine. Unfortunately, even if the infected person feels fine, he or she can pass the infection on to others.

Acquired Immune Deficiency Syndrome (AIDS)

AIDS is advanced HIV infection—it is the late stage of the infection, when the immune system is weakened.

Persons living with AIDS often have multiple infections, neurological disorders, extreme weight loss, diarrhea, and cancers. Although an infected person generally dies as a result of complications of these infections, conditions, and malignancies, living with AIDS is like living with other chronic diseases: sometimes the person feels sick, and at other times he or she feels fine and can go about normal activities.

How HIV Affects the Immune System

HIV is a retrovirus, a type of virus that stores its genetic information on a single-stranded RNA molecule. After a retrovirus penetrates a cell, it creates a DNA version of its genes, and its DNA becomes part of the infected cell’s DNA. HIV infects one particular type of immune system cell, called CD4 cells (or T-cells). T-cells coordinate immune regulation and secrete specialized factors that activate other white blood cells to fight off infection. In healthy individuals, the number of CD4 cells normally ranges from 450 to 1,200 cells per microliter of blood (T-cell count).
When infected with HIV, a T-cell becomes an HIV-replicating cell. In other words, the virus binds with the cell, copies itself into the cell’s DNA, and causes the cell to begin producing new HIV viruses. This process eventually causes the cell to die. As the number of T-cells decreases, the infected person’s immune system becomes increasingly compromised. When a person’s T-cell count drops to below 200 cells per microliter of blood, the person is considered to have AIDS. An infected person’s body tries to fight off HIV infection by aggressively manufacturing antibodies.

It is particularly difficult for the immune system to fight off HIV infection for a number of reasons, including the following:

- HIV attacks the immune system itself, weakening its ability to fight back.
- HIV replicates in large quantities that are more than the compromised immune system can handle.
- HIV has the ability to mutate very quickly, making it more difficult for the body to fight the infection.

**Current HIV/AIDS Epidemiology**

HIV infection and AIDS are among the most pressing concerns facing health providers worldwide. Although the impact of HIV/AIDS is serious in both developed and developing countries, it is most profound in the developing world, where resources to prevent, diagnose, and manage HIV infection are scarce.

The Joint United Nations Program on HIV/AIDS (UNAIDS) estimates that more than 40 million men, women, and children worldwide are now living with HIV/AIDS, of which 28 million are in Sub-Saharan Africa. In this region, 1 in 10 adults ages 15 to 49 is living with the virus, and in seven countries more than 20% of the population is infected. Women, especially young women, are becoming infected at alarmingly increasing rates. A great many infected people do not know they carry HIV and so may be spreading the virus to others unknowingly.

This global epidemic is now far more extensive than was predicted even a decade ago, and the challenges that HIV poses vary enormously from region to region. Since the beginning of the epidemic, AIDS has killed more than 21 million people, and it has replaced malaria and tuberculosis as the world’s leading cause of death by infectious disease among adults. AIDS is now the fourth leading cause of death among adults worldwide, and more than 13 million children have been orphaned by the epidemic.

Africa, Asia, and Latin America lead the world in HIV infection, with an estimated two-thirds of the world’s infections occurring in Africa, followed by 20% in Asia and 4% in Latin America and the Caribbean.

More than 21 million people have died from AIDS. However, a staggering 40 million people are currently living with HIV, and 5 million new infections are expected yearly.

**Identified Risk Behaviors**

Six common transmission categories are male-to-male sexual contact, injection drug use, male-to-male sexual contact and injection drug use, heterosexual contact, mother-
to-child (perinatal) transmission, and other (includes blood transfusions and unknown cause).

Following is the distribution of the estimated number of AIDS diagnoses among adults and adolescents by transmission category in the 50 states and the District of Columbia. A breakdown by sex is provided where appropriate.

<table>
<thead>
<tr>
<th>Transmission Category</th>
<th>Estimated # of AIDS Diagnoses, 2008</th>
<th>Cumulative Estimated # of AIDS Diagnoses, Through 2008*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adult and Adolescent Males</td>
<td>Adult and Adolescent Females</td>
</tr>
<tr>
<td>Male-to-male sexual contact</td>
<td>17,758</td>
<td>-</td>
</tr>
<tr>
<td>Injection drug use</td>
<td>3,555</td>
<td>2,286</td>
</tr>
<tr>
<td>Male-to-male sexual contact and injection drug use</td>
<td>1,704</td>
<td>-</td>
</tr>
<tr>
<td>Heterosexual contact*</td>
<td>4,301</td>
<td>7,112</td>
</tr>
<tr>
<td>Other</td>
<td>225</td>
<td>199</td>
</tr>
</tbody>
</table>

* Heterosexual contact with a person known to have, or to be at high risk for, HIV infection.
** Includes hemophilia, blood transfusion, perinatal exposure, and risk not reported or not identified.
*** Includes hemophilia, blood transfusion, perinatal exposure, and risk not reported or not identified.

** Opportunistic Diseases that Define AIDS**

No one dies from AIDS or HIV; rather, a person with AIDS dies from an infection or condition that his or her weakened immune system can no longer fight off.

In the U.S. and Europe, the average time from HIV infection to the development of AIDS is more than 11 years. In developing countries, the average time is shorter, which is probably due to multiple factors, including a higher background level of pre-existing infections; less access to care, including prophylaxis for opportunistic infections; and poor nutrition. Progress of the infection in infants is generally much faster than in adults.

Advanced infection with HIV weakens the immune system to the point that it cannot fight off infections as effectively as usual. The individual becomes more susceptible to a variety of opportunistic infections and other conditions (e.g., cancer). Some examples of opportunistic infections include:

- Candidiasis of bronchi, trachea, or lungs
- Candidiasis, esophageal
- Cervical cancer, invasive
- Coccidioidomycosis, disseminated or extrapulmonary
- Cryptococcosis, extrapulmonary
- Cryptosporidiosis, chronic intestinal (greater than 1 month’s duration)
- Cytomegalovirus disease (other than liver, spleen, or nodes)
- Cytomegalovirus retinitis (with loss of vision)
- Encephalopathy, HIV-related
• Herpes simplex: chronic ulcer(s) (greater than 1 month’s duration); or bronchitis, pneumonitis, or esophagitis
• Histoplasmosis, disseminated or extrapulmonary
• Isosporiasis, chronic intestinal (greater than 1 month’s duration)
• Kaposi’s sarcoma
• Lymphoma, Burkitt’s (or equivalent term)
• Lymphoma, immunoblastic (or equivalent term)
• Lymphoma, primary, of brain
• Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary
• Mycobacterium tuberculosis, any site (pulmonary or extrapulmonary)
• Mycobacterium, other species or unidentified species, disseminated or extrapulmonary
• Pneumocystis carinii pneumonia
• Pneumonia, recurrent
• Progressive multifocal leukoencephalopathy
• Salmonella septicemia, recurrent
• Toxoplasmosis of brain
• Wasting syndrome due to HIV

Oral Manifestations of HIV/AIDS

Oral manifestations are common in people with HIV infection. By some estimates, more than 90% of AIDS patients will have at least one HIV-related oral manifestation in the course of their disease. For some patients, the presence of these oral lesions may be the first sign of HIV infection, leading to testing and diagnosis. For others, oral lesions may signify a decline in immune function. For example, untreated HIV-infected patients with oral candidiasis have been shown to progress to an AIDS diagnosis within a two-year period.

Some of the more common oral manifestations seen in people with HIV infection include:
• Atrophic candidiasis
• Pseudomembranous candidiasis
• Oral hairy leukoplakia
• Hypertrophic candidiasis
• Kaposi’s sarcoma
• Necrotizing stomatitis
• Necrotizing ulcerative periodontitis
• Necrotizing ulcerative gingivitis
• CMV ulcers

Tests to Diagnose HIV infection

The most frequently used HIV tests detect the presence of antibodies to HIV, not the actual virus itself. A positive HIV antibody test indicates the presence of antibodies to the virus. A negative test result indicates either no antibodies or an undetectable level of antibodies to the virus. It is possible that these tests can miss infection in a person who was recently infected with HIV and has not yet developed enough antibodies to show a positive result.
The period of time from infection with HIV until the body has developed detectable antibody levels is called the window period. The window period is approximately three months on average. A person who is worried that he or she may have been exposed to infection should be encouraged to seek testing, and the counselor should explain that if the test comes back negative, it should be repeated after three months to confirm the result because the person could have been infected but still may be in the window period. During this period, a person may not test positive even if he or she is infected with HIV.

Types of HIV Tests

There are two broad categories of HIV tests: screening tests and confirmatory tests. Using these two types of test together can lead to highly accurate and reliable diagnosis of HIV infection.

Screening Tests

Screening tests are used for initial testing because they are easier to perform than confirmatory tests, well suited to testing large numbers of samples, and less costly. They are highly sensitive and result in few false negatives (i.e., most infected people test positive). However, screening tests are not as specific as confirmatory tests, so in a small percentage of cases the test result will be positive even if the person is not infected. Therefore, providers should never give results from screening tests that have not been verified through a confirmatory test.

ELISA Tests - The most common screening tests are enzyme-linked immunosorbent assay (ELISA) tests. These tests measure antibodies to HIV. Different types of ELISA tests are available. Most require serum specimens, though one uses urine and another uses an oral specimen.

- **Serum tests.** Traditional screening tests use a blood sample. About two dozen types of ELISA tests are in use around the world.
- **Urine tests.** An ELISA test for detecting HIV in urine samples has been approved for use in the U.S.; however, its biggest drawback is that there is no approved confirmatory test for urine samples (in other words, if the urine ELISA results are positive, a blood sample must then be drawn for confirmatory testing).
- **Oral tests.** OraSure is an HIV test that uses mucosal transudate as the sample. (Although some call this a saliva test, the sample is not saliva, but an oral sample called mucosal transudate.) The sample is collected by placing the special collection device between the cheek and gum. The specimen is then sent to a lab for ELISA testing. Positive ELISA results can be confirmed using the Western blot test. These tests are more expensive than blood tests. OraScreen, a similar test marketed for home use, is available in some countries, but it is not approved for use in the U.S.

Rapid Serologic Tests - Rapid serologic tests provide results in less than 30 minutes. These tests also measure antibodies to HIV, but by different mechanisms than ELISA tests, including agglutination tests, immunocomb tests, immunodot tests, and immunochromatographic membrane tests. Most rapid tests are kits that include all of the necessary supplies. These tests are relatively simple, involve a limited number of steps, and are quite accurate when performed correctly. (Most rapid tests require refrigeration.) While the inherent sensitivity and specificity of ELISA tests may be
greater than those of some of the rapid tests, the field performance of rapid tests is often as good as or better than the ELISA because the former is simpler and easier to do in a low-resource setting. One rapid HIV test is approved for use in the U.S. (Single Use Diagnostic System for HIV-1, or SUDS, manufactured by Murex Diagnostics, Inc.).

**HIV Dipstick Test Kit** - This is a rapid (results in approximately 20 minutes), inexpensive (less than $0.50/test) test that requires no specialized equipment. Sensitivity is more than 99%, and specificity is more than 98%. The dipsticks are licensed in many countries around the world and are currently being produced in Thailand, India, Argentina, and Indonesia. They are not licensed for use in the U.S.

**Confirmatory Tests**
A confirmatory test is done when the results of a screening test are positive. The confirmatory test is expensive and labor intensive and requires subjective interpretation, but it is very specific (in other words, false-positive results are extremely rare). The Western blot test is considered by most to be the “gold standard” for confirmation of positive screening test results. This test also measures antibodies to HIV, but it is more specific than screening tests and false positives are minimal. Another, less commonly used confirmatory test is the immunofluorescence assay (IFA). Positive results from ELISA or rapid tests are commonly confirmed using a Western blot.

**Alternate Testing Strategies**
Other testing strategies besides a screening test followed by a confirmatory test have been proposed by the WHO and UNAIDS for use in low-resource settings where the Western blot may not be readily available or affordable. These strategies include using a combination of two screening tests (ELISA or rapid tests) without using the Western blot. Studies have shown that the use of two screening tests together can give results similar to, or in some cases better than, the use of a screening test followed by a confirmatory test, at a much lower cost. It is important to note that results will vary depending on the combination of screening tests used, so it is necessary to evaluate the intended combination before undertaking widespread implementation.

**CDC’s Opt-Out Testing Recommendations**

The U.S. Centers for Disease Control and Prevention (CDC) now recommends testing all health care patients for HIV-regardless of their reported risk behaviors-using an “opt-out” approach in which patients are informed that an HIV test will be conducted unless they explicitly decline to be tested. These new testing procedures will facilitate the identification of persons living with HIV who are unaware of their infection.

CDC recommends that diagnostic HIV testing and opt-out HIV screening be a part of routine clinical care in all health-care settings while also preserving the patient’s option to decline HIV testing and ensuring a provider-patient relationship conducive to optimal clinical and preventive care. The recommendations are intended for providers in all health-care settings, including hospital EDs, urgent-care clinics, inpatient services, STD clinics or other venues offering clinical STD services, tuberculosis (TB) clinics, substance abuse treatment clinics, other public health clinics, community clinics, correctional health-care facilities, and primary care settings. The guidelines address HIV testing in health-care settings only; they do not modify existing guidelines concerning HIV counseling, testing, and referral for persons at high risk for HIV who seek or receive...
HIV testing in nonclinical settings (e.g., community-based organizations, outreach settings, or mobile vans).

Screening for HIV Infection

- In all health-care settings, screening for HIV infection should be performed routinely for all patients aged 13-64 years.
- All patients initiating treatment for TB should be screened routinely for HIV infection.
- All patients seeking treatment for STDs, including all patients attending STD clinics, should be screened routinely for HIV during each visit for a new complaint, regardless of whether the patient is known or suspected to have specific behavior risks for HIV infection.

Repeat Screening

- Health-care providers should subsequently test all persons likely to be at high risk for HIV at least annually. Persons likely to be at high risk include injection-drug users and their sex partners, persons who exchange sex for money or drugs, sex partners of HIV-infected persons, and MSM or heterosexual persons who themselves or whose sex partners have had more than one sex partner since their most recent HIV test.
- Health-care providers should encourage patients and their prospective sex partners to be tested before initiating a new sexual relationship.
- Repeat screening of persons not likely to be at high risk for HIV should be performed on the basis of clinical judgment.
- Unless recent HIV test results are immediately available, any person whose blood or body fluid is the source of an occupational exposure for a health-care provider should be informed of the incident and tested for HIV infection at the time the exposure occurs.

Consent and Pretest Information

- Screening should be voluntary and undertaken only with the patient's knowledge and understanding that HIV testing is planned.
- Patients should be informed orally or in writing that HIV testing will be performed unless they decline (opt-out screening). Oral or written information should include an explanation of HIV infection and the meanings of positive and negative test results, and the patient should be offered an opportunity to ask questions and to decline testing. With such notification, consent for HIV screening should be incorporated into the patient's general informed consent for medical care on the same basis as are other screening or diagnostic tests; a separate consent form for HIV testing is not recommended.
- Easily understood informational materials should be made available in the languages of the commonly encountered populations within the service area. The competence of interpreters and bilingual staff to provide language assistance to patients with limited English proficiency must be ensured.
- If a patient declines an HIV test, this decision should be documented in the medical record.

Diagnostic Testing for HIV Infection

- All patients with signs or symptoms consistent with HIV infection or an opportunistic illness characteristic of AIDS should be tested for HIV.
Clinicians should maintain a high level of suspicion for acute HIV infection in all patients who have a compatible clinical syndrome and who report recent high-risk behavior. When acute retroviral syndrome is a possibility, a plasma RNA test should be used in conjunction with an HIV antibody test to diagnose acute HIV infection.

Patients or persons responsible for the patient's care should be notified orally that testing is planned, advised of the indication for testing and the implications of positive and negative test results, and offered an opportunity to ask questions and to decline testing. With such notification, the patient's general consent for medical care is considered sufficient for diagnostic HIV testing.

Methods of Transmission and Prevention of HIV and Current Recognized Methods of Medical Treatment.

Methods of Transmission

HIV is spread through three main modes. These modes of transmission are as a result of exposure to body fluids (blood, semen, vaginal fluids, and breast milk) of infected individuals. Specifically, HIV can be transmitted through:

Sexual contact:
- Vaginal sex
- Anal sex
- Oral sex

Blood contact:
- Injections/needles (sharing needles, IV drugs, drug paraphernalia, or injury from contaminated needles or other sharp objects)
- Cutting tools (using contaminated skin-piercing instruments, such as scalpels, needles, razor blades, tattoo needles, circumcision instruments)
- Transfusions (receiving infected blood or blood products) or transplant of an infected organ
- Contact with broken skin (exposure to blood through cuts or lesions)

Mother-to-child transmission (MTCT):
- Pregnancy
- Delivery
- Breastfeeding

Although any exposure through one of these methods can lead to HIV infection, not every exposure results in transmission of the infection.

HIV can be detected in several fluids and tissue of a person living with HIV. It is important to understand however, that finding a small amount of HIV in a body fluid or tissue does not mean that HIV is transmitted by that body fluid or tissue. Only specific fluids (blood, semen, vaginal secretions, and breast milk) from an HIV-infected person can transmit HIV. These specific fluids must come in contact with a mucous membrane or damaged tissue or be directly injected into the blood-stream (from a needle or syringe) for transmission to possibly occur.
In the United States, HIV is most commonly transmitted through specific sexual behaviors (anal or vaginal sex) or sharing needles with an infected person. It is less common for HIV to be transmitted through oral sex or for an HIV-infected woman to pass the virus to her baby before or during childbirth or after birth through breastfeeding or by prechewing food for her infant. In the United States, it is also possible to acquire HIV through exposure to infected blood, transfusions of infected blood, blood products, or organ transplantation, though this risk is extremely remote due to rigorous testing of the U.S. blood supply and donated organs.

Some healthcare workers have become infected after being stuck with needles containing HIV-infected blood or, less frequently, when infected blood comes in contact with a worker's open cut or is splashed into a worker's eyes or inside their nose. There has been only one instance of patients being infected by an HIV-infected dentist.

**Body Fluids That Transmit HIV**

These body fluids have been shown to contain high concentrations of HIV:

- blood
- semen
- vaginal fluid
- breast milk
- other body fluids containing blood

The following are additional body fluids that may transmit the virus that health care workers may come into contact with:

- fluid surrounding the brain and the spinal cord
- fluid surrounding bone joints
- fluid surrounding an unborn baby

**HIV From Anal Sex**

Unprotected (without a condom) anal sex is considered to be very risky behavior. It is possible for either sex partner to become infected with HIV during anal sex. HIV can be found in the blood, semen, pre-semenal fluid, or vaginal fluid of a person infected with the virus. In general, the person receiving the semen is at greater risk of getting HIV because the lining of the rectum is thin and may allow the virus to enter the body during anal sex. However, a person who inserts his penis into an infected partner also is at risk because HIV can enter through the urethra (the opening at the tip of the penis) or through small cuts, abrasions, or open sores on the penis.

Not having (abstaining from) sex is the most effective way to avoid HIV. If people choose to have anal sex, they should use a latex condom. Most of the time, condoms work well. However, condoms are more likely to break during anal sex than during vaginal sex. Thus, even with a condom, anal sex can be risky. A person should use generous amounts of water-based lubricant in addition to the condom to reduce the chances of the condom breaking.

**HIV from Vaginal Sex**

It is possible for either partner to become infected with HIV through vaginal sex. In fact, it is the most common way the virus is transmitted in much of the world. HIV can be found in the blood, semen, pre-semenal fluid or vaginal fluid of a person infected with the virus.
In women, the lining of the vagina can sometimes tear and possibly allow HIV to enter the body. HIV can also be directly absorbed through the mucous membranes that line the vagina and cervix.

In men, HIV can enter the body through the urethra or through small cuts or open sores on the penis.

Abstaining from sex is the most effective way to avoid HIV. Studies have shown that latex condoms are very effective, though not perfect, in preventing HIV transmission when used correctly and consistently. If either partner is allergic to latex, plastic (polyurethane) condoms for either the male or female can be used.

**HIV from Oral Sex**

It is possible for either partner to become infected with HIV through performing or receiving oral sex, though it is a less common mode of transmission than other sexual behaviors (anal and vaginal sex). There have been a few cases of HIV transmission from performing oral sex on a person infected with HIV. While no one knows exactly what the degree of risk is, evidence suggests that the risk is less than that of unprotected anal or vaginal sex.

If the person receiving oral sex has HIV, their blood, semen, pre-seminal fluid, or vaginal fluid may contain the virus. Cells lining the mouth of the person performing oral sex may allow HIV to enter their body.

**HIV from Injecting Drugs**

At the start of every intravenous injection, blood is introduced into the needle and syringe. HIV can be found in the blood of a person infected with the virus. The reuse of a blood-contaminated needle or syringe by another drug injector (sometimes called "direct syringe sharing") carries a high risk of HIV transmission because infected blood can be injected directly into the bloodstream.

Sharing drug equipment can be a risk for spreading HIV. Infected blood can be introduced into drug solutions by:

- using blood-contaminated syringes to prepare drugs;
- reusing water;
- reusing bottle caps, spoons, or other containers ("spoons" and "cookers") used to dissolve drugs in water and to heat drug solutions; or
- reusing small pieces of cotton or cigarette filters ("cottons") used to filter out particles that could block the needle.

"Street sellers" of syringes may repackage used syringes and sell them as sterile syringes. For this reason, people who continue to inject drugs should obtain syringes from reliable sources of sterile syringes, such as pharmacies.

**HIV Survival Outside of the Body**

Scientists and medical authorities agree that HIV does not survive well outside the body, making the possibility of environmental transmission remote. HIV is found in varying concentrations or amounts in blood, semen, vaginal fluid, breast milk, saliva, and tears. To obtain data on the survival of HIV, laboratory studies have required the use of artificially high concentrations of laboratory-grown virus. Although these unnatural concentrations of HIV can be kept alive for days or even weeks under precisely...
controlled and limited laboratory conditions, CDC studies have shown that drying of even these high concentrations of HIV reduces the amount of infectious virus by 90 to 99 percent within several hours. Since the HIV concentrations used in laboratory studies are much higher than those actually found in blood or other specimens, drying of HIV-infected human blood or other body fluids reduces the theoretical risk of environmental transmission to that which has been observed—essentially zero. Incorrect interpretations of conclusions drawn from laboratory studies have in some instances caused unnecessary alarm.

Results from laboratory studies should not be used to assess specific personal risk of infection because (1) the amount of virus studied is not found in human specimens or elsewhere in nature, and (2) no one has been identified as infected with HIV due to contact with an environmental surface. Additionally, HIV is unable to reproduce outside its living host (unlike many bacteria or fungi, which may do so under suitable conditions), except under laboratory conditions; therefore, it does not spread or maintain infectiousness outside its host.

**HIV Transmission Myths**

Many myths exist about how HIV is transmitted, and many myths are culturally specific. It is important that people realize that HIV is actually quite difficult to transmit. For example, it is far less transmissible than hepatitis B or some other STIs.

HIV is NOT transmitted through:
- Ordinary social or casual contact
- Donating blood
- Shared clothing
- Touching
- Shared food or dishes
- Dry kissing
- Shaking hands
- Toilet seats
- Insect bites
- Massaging another person
- Sexually stimulating a partner using your hand (although a risk may exist if blood, semen, or vaginal fluids come in contact with broken skin)
- Masturbation
- Living with a person with HIV

In addition, HIV is not transmitted through tears, sweat, saliva, vomit, feces, or urine. Although these substances can contain HIV, they do not contain the virus in amounts significant enough to cause infection. Extensive, continuing studies of new HIV infections over the last 20 years in many countries have not uncovered any cases of infection through these substances. Blood, semen, vaginal secretions, and breast milk are the only body fluids through which HIV transmission has been documented.

**Methods of Prevention (for Each Method of Transmission)**

**HIV Prevention for Sexually Active Individuals**

Abstaining from sex is the most effective way to avoid HIV.
When used consistently and correctly, condoms (and other latex barriers such as dental dams) are the best way to prevent the spread of HIV during sexual activity. Condoms can protect the mouth, vagina or rectum from HIV-infected semen. They can protect the penis from HIV-infected vaginal fluids and blood in the mouth, vagina, or rectum. They also reduce the risk of spreading other sexually transmitted diseases.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of HIV.

Epidemiologic studies that are conducted in real-life settings, where one partner is infected with HIV and the other partner is not, demonstrate that the consistent use of latex condoms (and dental dams) provides a high degree of protection.

**HIV Prevention for Intravenous Drug Users (IDU)**

Current disinfection recommendations are based on the following steps:

- Flush out blood, drugs, and other organic matter from the syringe. These can contain viruses and do interfere with the disinfection process.
- Disinfect the syringe.
- Rinse out the disinfectant.

The idea behind these steps is to reduce the risk of HIV transmission in two ways. First, flushing removes blood and drugs from the syringe, which reduces the number of viral particles. Second, using a disinfectant can kill remaining viruses so they can’t infect anyone else.

Instructions for disinfecting syringes usually include ways to make sure that viruses are removed and killed:

- Fill the syringe with clean water (such as water right from a tap or a new bottle of water).
- Shake or tap the syringe containing water or disinfectant (this dislodges particles and thoroughly mixes the water or disinfectant with material in the syringe); then squirt out and throw away the water; repeat until no more blood can be seen.
- Leave the water or disinfectant, especially the disinfectant, in the syringe for a while (in principle, the longer the better; for example, 30 seconds is better than 15 seconds); then squirt out the disinfectant.
- Rinse out the syringe with clean water (fill syringe, shake or tap, squirt out and throw away water); rinsing is done to get rid of disinfectant and any viruses left in the syringe.

**Perinatal Transmission and Prevention**

Most mother-to-child transmission of HIV occurs around the time of labor and delivery. Therefore, HIV treatment during this time is very important for protecting the baby from HIV infection.

Several treatments can be used together to reduce the risk of transmission to the baby.

1. Highly active antiretroviral therapy (HAART) is recommended even for HIV-infected pregnant women who do not need treatment for their own health. If possible, HAART should include AZT (Retrovir or zidovudine).
2. During labor and delivery, the mother should receive intravenous (IV) AZT.
3. The baby should take AZT (in liquid form) every 6 hours for 6 weeks after birth. If the mother has been taking any other anti-HIV medications during pregnancy, the doctor will probably recommend that she continue to take them on schedule during labor. Better understanding of HIV transmission has contributed to dramatically reduced rates of mother-to-child transmission of HIV.

**Delivery options**

Cesarean delivery - is recommended for an HIV positive mother when:
- her viral load is unknown or is greater than 1,000 copies/mL at 36 weeks of pregnancy.
- she has not taken any anti-HIV medications or has only taken AZT (Retrovir or zidovudine) during her pregnancy.
- she has not received prenatal care until 36 weeks into her pregnancy or later.

Vaginal delivery - is recommended for an HIV positive mother when:
- she has been receiving prenatal care throughout her pregnancy
- she has a viral load less than 1,000 copies/mL at 36 weeks
- she has ruptured membranes and labor is progressing rapidly.

**Post-natal HIV Prevention**

It is recommended that all babies born to HIV positive mothers receive a 6-week course of oral AZT to help prevent mother-to-child transmission of HIV. This oral AZT regimen should begin within 6 to 12 hours after the baby is born.

In addition to HIV treatment, the baby should also receive treatment to prevent P. carinii/jiroveci pneumonia (PCP). The recommended treatment is a combination of the medications sulfamethoxazole and trimethoprim. This treatment should be started when the baby is 4 to 6 weeks old and the 6-week course of AZT is complete. The treatment should continue until the baby is confirmed to be HIV negative.

Breastfeeding - The CDC recommends that women not breastfeed in areas where safe drinking water and infant formula are available (such as the United States). This is recommended to avoid transmission of HIV to infants through breast milk.

**Current Medical Treatment for HIV infection**

The Food and Drug Administration has approved a number of drugs for treating HIV infection. The first group of drugs used to treat HIV infection, reverse transcriptase inhibitors, interrupts an early stage of the virus making copies of itself. There are two subgroups included in this category; nucleoside and nonnucleoside. Included in the nucleoside group are AZT (zidovudine or ZDV), ddc (zalcitabine), ddI (dideoxyinosine), d4T ( stavudine), and 3TC (lamivudine). The nonnucleoside group includes delvaridine (Rescriptor), and nevirapine (Viramune). Both subgroups of these drugs slow the spread of HIV in the body and delay the onset of opportunistic infections.

Protease inhibitors are the second major group of drugs approved to treat HIV infection. These drugs act to limit the virus’s ability to cleave itself into small infectious pieces. They accomplish this by restricting the production of a specific protein that is required to...
perform the process. Drugs in this category include indinavir (Crixivan), neflunavir (Viracept), ritonavir (Norvir), and saquinavir (Invirase).

Because HIV can become resistant to both classes of drugs, combination treatment using both is necessary to effectively suppress the virus.

Currently available antiretroviral drugs do not cure people of HIV infection or AIDS, and they all have side effects that can be severe. Some of the Nucleoside RT inhibitors may cause a depletion of red or white blood cells, especially when taken in the later stages of the disease. Some may also cause an inflammation of the pancreas and painful nerve damage. Other complications, including lactic acidosis and severe hepatomegaly with steatosis that may result in liver failure and death, have also been reported with the use or antiretroviral nucleoside analogs alone or in combination.

Researchers have credited highly active antiretroviral therapy (HAART) as being a major factor in reducing the number of deaths from AIDS in the U.S. HAART is a combination of several drugs including reverse transcriptase inhibitors and protease inhibitors.

A number of drugs are also available to help treat opportunistic infections. These drugs include foscarnet and ganciclovir, used to treat cytomegalovirus eye infections, fluconazole to treat yeast and other fungal infections, and trimethoprim/sulfamethoxazole or pentamidine to treat Pneumocystis carinii pneumonia. (PCP).

Management of HIV in the Healthcare Workplace

OSHA Bloodborne Pathogens Standards

In 1983, CDC published a document entitled "Guideline for Isolation Precautions in Hospitals" that contained a section entitled "Blood and Body Fluid Precautions." The recommendations in this section called for blood and body fluid precautions when a patient was known or suspected to be infected with bloodborne pathogens. In August 1987, CDC published a document entitled "Recommendations for Prevention of HIV Transmission in Health-Care Settings" (1). In contrast to the 1983 document, the 1987 document recommended that blood and body fluid precautions be consistently used for all patients regardless of their bloodborne infection status. This extension of blood and body fluid precautions to all patients is referred to as "Universal Blood and Body Fluid Precautions" or "Universal Precautions." Under universal precautions, blood and certain body fluids of all patients are considered potentially infectious for human immunodeficiency virus (HIV), hepatitis B virus (HBV), and other bloodborne pathogens. Universal precautions are intended to prevent parenteral, mucous membrane, and nonintact skin exposures of health-care workers to bloodborne pathogens. In addition, immunization with HBV vaccine is recommended as an important adjunct to universal precautions for health-care workers who have exposures to blood.

Body Fluids to Which Universal Precautions Apply

Universal precautions apply to blood and to other body fluids containing visible blood. Occupational transmission of HIV to health-care workers by blood is documented. Blood is the single most important source of HIV and other bloodborne pathogens in the occupational setting.
Universal precautions also apply to semen and vaginal secretions. Although both of these fluids have been implicated in the sexual transmission of HIV, they have not been implicated in occupational transmission from patient to health-care worker. This observation is not unexpected, since exposure to semen in the usual health-care setting is limited, and the routine practice of wearing gloves for performing vaginal examinations protects health-care workers from exposure to potentially infectious vaginal secretions.

Universal precautions also apply to tissues and to the following fluids: cerebrospinal fluid (CSF), synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, and amniotic fluid. The risk of transmission of HIV from these fluids is unknown. However, HIV has been isolated from CSF, synovial, and amniotic fluid.

**Body Fluids to Which Universal Precautions Do Not Apply**
Universal precautions do not apply to feces, nasal secretions, sputum, sweat, tears, urine, and vomitus unless they contain visible blood. The risk of transmission of HIV from these fluids and materials is extremely low or nonexistent. HIV has been isolated in some of these fluids; however, epidemiologic studies in the health-care and community setting have not implicated these fluids or materials in the transmission of HIV infections.

**Use of Protective Barriers**
Protective barriers reduce the risk of exposure of the health-care worker's skin or mucous membranes to potentially infective materials. For universal precautions, protective barriers reduce the risk of exposure to blood, body fluids containing visible blood, and other fluids to which universal precautions apply. Examples of protective barriers include gloves, gowns, masks, and protective eyewear. Gloves should reduce the incidence of contamination of hands, but they cannot prevent penetrating injuries due to needles or other sharp instruments. Masks and protective eyewear or face shields should reduce the incidence of contamination of mucous membranes of the mouth, nose, and eyes.

Universal precautions are intended to supplement rather than replace recommendations for routine infection control, such as handwashing and using gloves to prevent gross microbial contamination of hands. Because specifying the types of barriers needed for every possible clinical situation is impractical, some judgment must be exercised. The risk of nosocomial transmission of HIV and other bloodborne pathogens can be minimized if health-care workers use the following general guidelines:

1. Take care to prevent injuries when using needles, scalpels, and other sharp instruments or devices; when handling sharp instruments after procedures; when cleaning used instruments; and when disposing of used needles. Do not recap used needles by hand; do not remove used needles from disposable syringes by hand; and do not bend, break, or otherwise manipulate used needles by hand. Place used disposable syringes and needles, scalpel blades, and other sharp items in puncture-resistant containers for disposal. Locate the puncture-resistant containers as close to the use area as is practical.

2. Use protective barriers to prevent exposure to blood, body fluids containing visible blood, and other fluids to which universal precautions apply. The type of protective barrier(s) should be appropriate for the procedure being performed and the type of exposure anticipated.
3. Immediately and thoroughly wash hands and other skin surfaces that are contaminated with blood, body fluids containing visible blood, or other body fluids to which universal precautions apply.

HIV Post Exposure Prophylaxis (PEP)

Health care providers (HCP) exposed to HIV should be evaluated within hours (rather than days) after their exposure and should be tested for HIV at baseline (i.e., to establish infection status at the time of exposure). If the source person is seronegative for HIV, baseline testing or further follow-up of the exposed person normally is not necessary. Serologic testing should be made available to all HCP who are concerned that they might have been occupationally infected with HIV. For purposes of considering HIV PEP, the evaluation also should include information about medications the exposed person might be taking and any current or underlying medical conditions or circumstances (i.e., pregnancy, breast feeding, or renal or hepatic disease) that might influence drug selection.

Recommendations for the Selection of Drugs for HIV PEP

Health-care providers must strive to balance the risk for infection against the potential toxicity of the agent(s) used when selecting a drug regimen for HIV PEP. Because PEP is potentially toxic, its use is not justified for exposures that pose a negligible risk for transmission. Also insufficient evidence exists to support recommending a three-drug regimen for all HIV exposures. Therefore, two regimens for PEP are provided: a “basic” two-drug regimen that includes two nucleoside analogues (e.g., ZDV and 3TC; or 3TC and d4T; or d4T and ddI); and an “expanded” three-drug regimen that should be used for exposures that pose an increased risk for transmission. When possible, the regimens should be implemented in consultation with persons who have expertise in antiretroviral treatment and HIV transmission. Reevaluation of the exposed person should be considered within 72 hours postexposure, especially as additional information about the exposure or source person becomes available.

Basic Regimen

Zidovudine (RETROVIR™; ZDV; AZT) + Lamivudine (EPIVIR™; 3TC); available as COMBIVIR™

- ZDV: 600 mg per day, in two or three divided doses, and
- 3TC: 150 mg twice daily.

Alternative Basic Regimen

Lamivudine (3TC) + Stavudine (ZERIT™; d4T)

- 3TC: 150 mg twice daily, and
- d4T: 40 mg twice daily.

Didanosine (VIDEX™, chewable/dispersible buffered tablet; VIDEX™ EC, delayed-release capsule; ddl) + Stavudine (d4T)

- ddl: 400 mg daily, on an empty stomach.
- d4T: 40 mg twice daily.

Expanded Regimen (Basic regimen plus one of the following):

Indinavir (CRIXIVAN™; IDV) - 800 mg every 8 hours, on an empty stomach.
Nelfinavir (VIRACEPT™; NFV) - 750 mg three times daily, or 1250 mg twice daily
Efavirenz (SUSTIVA™; EFV) - 600 mg daily, at bedtime.
Abacavir (ZIAGEN™; ABC) - 300 mg twice daily
Legal Issues Surrounding HIV Infection

Consent to Test

214.625 Legislative findings -- Consent for medical procedures and tests including HIV infection
(2) A person who has signed a general consent form for the performance of medical procedures and tests is not required to also sign or be presented with a specific consent form relating to medical procedures or tests to determine human immunodeficiency virus infection, antibodies to human immunodeficiency virus, or infection with any other causative agent of acquired immunodeficiency syndrome that will be performed on the person during the time in which the general consent form is in effect. However, a general consent form shall instruct the patient that, as part of the medical procedures or tests, the patient may be tested for human immunodeficiency virus infection, hepatitis, or any other blood-borne infectious disease if a doctor or advanced practice registered nurse orders the test for diagnostic purposes. Except as otherwise provided in subsection (5)(c) of this section, the results of a test or procedure to determine human immunodeficiency virus infection, antibodies to human immunodeficiency virus, or infection with any probable causative agent of acquired immunodeficiency syndrome performed under the authorization of a general consent form shall be used only for diagnostic or other purposes directly related to medical treatment.

(3) In any emergency situation where informed consent of the patient cannot reasonably be obtained before providing health-care services, there is no requirement that a health-care provider obtain a previous informed consent.

Confidentiality Issues

214.625 Legislative findings -- Confidentiality of results
5 (c) No person who has obtained or has knowledge of a test result pursuant to this section shall disclose or be compelled to disclose the identity of any person upon whom a test is performed, or the results of the test in a manner which permits identification of the subject of the test, except to the following persons:
1. The subject of the test or the subject's legally authorized representative;
2. Any person designated in a legally effective release of the test results executed prior to or after the test by the subject of the test or the subject's legally authorized representative;
3. A physician, nurse, or other health-care personnel who has a legitimate need to know the test result in order to provide for his protection and to provide for the patient's health and welfare;
4. Health-care providers consulting between themselves or with health-care facilities to determine diagnosis and treatment;
5. The cabinet, in accordance with rules for reporting and controlling the spread of disease, as otherwise provided by state law;
6. A health facility or health-care provider which procures, processes, distributes, or uses:
   a. A human body part from a deceased person, with respect to medical information regarding that person; or
   b. Semen provided prior to July 13, 1990, for the purpose of artificial insemination;
7. Health facility staff committees, for the purposes of conducting program monitoring, program evaluation, or service reviews;
8. Authorized medical or epidemiological researchers who shall not further disclose any identifying characteristics or information;
9. A parent, foster parent, or legal guardian of a minor; a crime victim; or a person specified in KRS 438.250;
10. A person allowed access by a court order which is issued in compliance with the following provisions:
   a. No court of this state shall issue an order to permit access to a test for human immunodeficiency virus performed in a medical or public health setting to any person not authorized by this section or by KRS 214.420. A court may order an individual to be tested for human immunodeficiency virus only if the person seeking the test results has demonstrated a compelling need for the test results which cannot be accommodated by other means. In assessing compelling need, the court shall weigh the need for testing and disclosure against the privacy interest of the test subject and the public interest which may be disserved by disclosure which deters blood, organ, and semen donation and future human immunodeficiency virus-related testing or which may lead to discrimination. This paragraph shall not apply to blood bank donor records;
   b. Pleadings pertaining to disclosure of test results shall substitute a pseudonym for the true name of the subject of the test. The disclosure to the parties of the subject's true name shall be communicated confidentially, in documents not filed with the court;
   c. Before granting any order, the court shall provide the individual whose test result is in question with notice and a reasonable opportunity to participate in the proceedings if he is not already a party;
   d. Court proceedings as to disclosure of test results shall be conducted in camera, unless the subject of the test agrees to a hearing in open court or unless the court determines that a public hearing is necessary to the public interest and the proper administration of justice; and
   e. Upon the issuance of an order to disclose test results, the court shall impose appropriate safeguards against unauthorized disclosure, which shall specify the persons who may have access to the information, the purposes for which the information shall be used, and appropriate prohibitions on future disclosure.
   No person to whom the results of a test have been disclosed shall disclose the test results to another person except as authorized by this subsection. When disclosure is made pursuant to this subsection, it shall be accompanied by a statement in writing which includes the following or substantially similar language: "This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose." An oral disclosure shall be accompanied by oral notice and followed by a written notice within ten (10) days.

Kentucky HIV/AIDS Reporting Requirements

902 KAR 2:020. Disease surveillance.
Section 7. Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) Surveillance.

(1) Physicians and Medical Laboratories shall report:
   (a)1. A positive test result for HIV infection including a result from:

Innovative Educational Services
To take the post-test for CE credit, go to: www.cheapceus.com

Create PDF files without this message by purchasing novaPDF printer (http://www.novapdf.com)
a. Elisa;  
b. Western Blot;  
c. PCR;  
d. HIV antigen; or  
e. HIV culture;  
2. CD4+ assay including absolute CD4+ cell counts and CD4+%;  
3. HIV detectable Viral Load Assay; and  
4. A positive serologic test result for HIV infection; or  

(b) A diagnosis of AIDS that meets the definition of AIDS established within the Centers for Disease Control and Prevention (CDC) guidelines and reported in the:  
   1. "Adult HIV/AIDS Confidential Case Report Form," or  
   2. "Pediatric HIV/AIDS Confidential Case Report Form."  

(2) An HIV infection or AIDS diagnosis shall be reported within five (5) business days and, if possible, on the "Adult HIV/AIDS Confidential Case Report form" or the "Pediatric HIV/AIDS Confidential Case Report form."  

(a) A report for a resident of Jefferson, Henry, Oldham, Bullitt, Shelby, Spencer, and Trimble Counties shall be submitted to the HIV/AIDS Surveillance Program of the Louisville-Metro Health Department.  
(b) A report for a resident of the remaining Kentucky counties shall be submitted to the HIV/AIDS Surveillance Program of the Kentucky Department for Public Health, or as directed by the HIV/AIDS project coordinator.  

(3) A report for a person with HIV infection without a diagnosis of AIDS shall include the following information:  
   (a) The patient's full name;  
   (b) Date of birth, using the format MMDDYY;  
   (c) Gender;  
   (d) Race;  
   (e) Risk factor, as identified by CDC;  
   (f) County of residence;  
   (g) Name of facility submitting report;  
   (h) Date and type of HIV test performed;  
   (i) Results of CD4+ cell counts and CD4+%;  
   (j) Results of viral load testing;  
   (k) PCR, HIV culture, HIV antigen, if performed;  
   (l) Results of TB testing, if available; and  
   (m) HIV status of the person's partner, spouse or children.  

(4) Reports of AIDS cases shall include the information in subsections (1) through (3)  
   (a) The patient's complete address;  
   (b) Opportunistic infections diagnosed; and  
   (c) Date of onset of illness.  

(5) (a) Reports of AIDS shall be made whether or not the patient has been previously reported as having HIV infection  

Americans with Disabilities Act  

The Americans with Disabilities Act (ADA) gives federal civil rights protections to individuals with disabilities similar to those provided to individuals on the basis of race, color, sex, national origin, age, and religion. It guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, State and local government services, and telecommunications.  

An individual is considered to have a "disability" if he or she has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment. Persons with HIV disease,
both symptomatic and asymptomatic, have physical impairments that substantially limit one or more major life activities and are, therefore, protected by the law.

Persons who are discriminated against because they are regarded as being HIV-positive are also protected. For example, a person who was fired on the basis of a rumor that he had AIDS, even if he did not, would be protected by the law.

Moreover, the ADA protects persons who are discriminated against because they have a known association or relationship with an individual who is HIV-positive. For example, the ADA would protect an HIV-negative woman who was denied a job because her roommate had AIDS.

**Appropriate Attitudes and Behaviors**

**Stigma**

Stigma can be defined as an attribute or quality which significantly ‘discredits’ an individual in the eyes of others. This means that people will look at someone and have a negative attitude towards that person because of a certain quality or characteristic, for example the person is known or suspected to be HIV-positive. Stigma allows people living with HIV/AIDS (PLHA) to be treated differently from other people. This is what we mean by discrimination. Discrimination is a form of behavior which results in unequal/unjustifiable treatment. It is important to note that stigmatizing attitudes do not always translate into discrimination, but the effect of the negative attitude may still be damaging or hurtful to the PLHA.

**Cultural Sensitivity of the Caregiver**

Cultural competence and sensitivity is an essential element of quality health care and can help improve health outcomes, increase clinic efficiency, and produce greater patient satisfaction. Cultural competence is generally understood to be a set of attitudes, skills, behaviors, and policies that enable organizations and staff to work effectively in cross-cultural situations. Furthermore, it reflects the ability to acquire and use knowledge of the health-related beliefs, attitudes, practices, and communication patterns of patients and their families in order to improve services, strengthen programs, increase community participation, and close the gaps in health status among diverse population groups.

To practice cultural sensitivity, health care providers and other program staff should understand the ethnic and cultural needs of the populations they serve. Providing effective care involves taking the time and effort to learn from patients what is important to them in the experience of illness and treatment. Culture does matter in the clinic, and providers must remember that they too bring a cultural perspective to the patient-provider relationship.

**How Infection Occurred is Not the Issue**

Moral judgment continues to fuel discrimination against people living with HIV infection. Those who consider a person with HIV to be morally responsible for his or her HIV
infection are more likely to harbor feelings of anger, blame and disgust towards PLWH and/or support coercive and discriminatory HIV policies. National surveys reveal that PLWH continue to experience significant levels of moral judgment by their peers:

- 40% of respondents agreed with the statement "In general, it's people's own fault if they get AIDS."
- 48.3% believed that "Most people with AIDS are responsible for having their illness."
- And 24.8% believed "People who got AIDS through sex or drug use have gotten what they deserve."

**Caregivers’ Prejudices Toward Certain Risk Behavioral Practices**

How people become infected and the degree to which they are deemed to be culpable (or not) has, from very early on, structured debate and decisions about access to resources. A classic formulation is the distinction between those who are deemed “guilty” and those who are “innocent.”

Accessing health care can be a challenge for people who are HIV positive, because the health care system itself is often a source of stigma. Health care professionals, particularly those who infrequently encounter HIV-positive people, can be insensitive to their patients’ concerns about stigma. In addition, health care professionals are not always knowledgeable about appropriate procedures for maintaining patient confidentiality.

The literature on caregiving reveals that stigmatization is evident among health care providers. Fear of contagion and fear of death have clear negative effects on health care providers’ attitudes toward and treatment of HIV-positive patients.

Stigma and discrimination are recognized as two key factors that need to be addressed to create an effective and sustained response for HIV prevention, care, treatment, and impact mitigation. The effects of HIV-related stigma and discrimination can be felt on many levels: individual, family, community, programmatic, and societal. They represent obstacles such as preventing individuals from being tested; preventing persons from recognizing that they or family members are HIV positive; inhibiting people from seeking care, support, and treatment; causing people to mislead others; impeding people from using protection in intimate relations; preventing quality care and treatment; increasing social inequities; hindering the access of people living with HIV to housing, education, employment, and mobility; negatively affecting quality of life; and, eventually, leading to increased transmission, morbidity, and mortality.

Enacted stigma describes a process that moves beyond perceptions and attitudes and into actions. It consistently follows a similar three-step pattern: identify those infected, create a distance between oneself and “them,” and restrict or exclude “them.” Testing followed by violation of confidentiality is a common example of enacted stigma. Labeling or marking people living with HIV, avoidance, isolation or segregation, and differential treatment or prohibiting actions are also recurring aspects. Unconscious actions and institutionally sanctioned actions are often part of enacted stigma.
“Golden Rule” Approach

The Golden Rule is a maxim that essentially states the following: “One should treat others as one would like others to treat oneself.” The Golden Rule is arguably the most essential basis for the modern concept of human rights, in which each individual has a right to just treatment, and a responsibility to ensure justice for others. A key element of the Golden Rule is that a person attempting to live by this rule treats all people with consideration, not just members of his or her in-group.

Comprehensive Human Services Available

Kentucky’s Ryan White & State Funded Services Programs

Kentucky HIV Direct Services

Mission: To enhance access to and retention in primary health care and support services for qualifying Kentuckians (clients) living with HIV disease.

Goals of Kentucky HIV Direct Services
1. Client self sufficiency (to the extent possible) through good care plan monitoring and holistic support
2. Prevent duplication of health and support services among providers
3. Education about HIV disease transmission and health choices
4. Ongoing HIV disease education to the general and health care communities
5. Efficient and effective use of resources

Structure of Kentucky HIV Direct Services

Kentucky Care Coordination Program ( KHCCP ) - A network of regional sites by which clients may access quality primary health care and other support services in or near the communities in which they live. In order to access direct services in Kentucky, you must enroll in the KHCCP

Kentucky AIDS Drug Assistance Program (KADAP) – Provides clients with HIV/AIDS related medications

Kentucky Health Insurance Continuation Program (KHICP) – Assists clients with maintaining pre-existing private health insurance

Funding
Kentucky receives federal funding through the Ryan HIV/AIDS Treatment and Modernization Act of 2006, and also non-federal funds through the State of Kentucky

Eligibility Criteria (Proof required)
- Household income must be 300% or less of the current federal poverty level
- Total cash assets must be less than $10,000
- Must be a resident of Kentucky
- Must be HIV positive
- You cannot be eligible for similar assistance from another payer source
# HIV/AIDS - KENTUCKY

## HIV Care Coordinator Regions

### Barren River Region

**Matthew 25**

<table>
<thead>
<tr>
<th>Counties Covered:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allen</td>
</tr>
<tr>
<td>Barren</td>
</tr>
<tr>
<td>Breckinridge</td>
</tr>
<tr>
<td>Buller</td>
</tr>
<tr>
<td>Daviess</td>
</tr>
<tr>
<td>Edmonson</td>
</tr>
<tr>
<td>Grayson</td>
</tr>
<tr>
<td>Hancock</td>
</tr>
<tr>
<td>452 Old Corydon Road, Henderson, KY 42420 (270) 826-0200 (877) 428-1231 fax: (270) 826-0212</td>
</tr>
</tbody>
</table>

### Cumberland Valley Region

**Cumberland Valley District H D**

<table>
<thead>
<tr>
<th>Counties Covered:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adair</td>
</tr>
<tr>
<td>Bell</td>
</tr>
<tr>
<td>Breathitt</td>
</tr>
<tr>
<td>Casey</td>
</tr>
<tr>
<td>Clay</td>
</tr>
<tr>
<td>Clinton</td>
</tr>
<tr>
<td>Cumberland</td>
</tr>
<tr>
<td>Floyd</td>
</tr>
<tr>
<td>Green</td>
</tr>
<tr>
<td>Harlan</td>
</tr>
<tr>
<td>103 Chera Lynn Lane, London, KY 40741 (606) 864-3776 (888) 423-7282 fax: (606) 864-3732 * for client use only</td>
</tr>
</tbody>
</table>

### Lexington Region

**Bluegrass Care Clinic, UK**

<table>
<thead>
<tr>
<th>Counties Covered:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anderson</td>
</tr>
<tr>
<td>Bath</td>
</tr>
<tr>
<td>Bourbon</td>
</tr>
<tr>
<td>Boyd</td>
</tr>
<tr>
<td>Boyle</td>
</tr>
<tr>
<td>Bracken</td>
</tr>
<tr>
<td>Carter</td>
</tr>
<tr>
<td>Clark</td>
</tr>
<tr>
<td>740 S. Limestone, 5D Room L528 UK Medical Center, Lexington, KY 40536 (859) 323-5544</td>
</tr>
</tbody>
</table>

### Louisville Region

**Volunteers of America**

<table>
<thead>
<tr>
<th>Counties Covered:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bullitt</td>
</tr>
<tr>
<td>Henry</td>
</tr>
<tr>
<td>850 Barret Ave., Suite 302, Louisville, KY 40204 (502) 574-0161</td>
</tr>
</tbody>
</table>

### Northern Kentucky Region

**No. Ky Dist Health Department**

<table>
<thead>
<tr>
<th>Counties Covered:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boone</td>
</tr>
<tr>
<td>Campbell</td>
</tr>
<tr>
<td>Carroll</td>
</tr>
<tr>
<td>610 Medical Village Drive, Edgewood, KY 41017 (859) 341-4264 fax: (859) 578-3689</td>
</tr>
</tbody>
</table>

### Purchase Region

**Heartland Cares, Inc.**

<table>
<thead>
<tr>
<th>Counties Covered:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ballard</td>
</tr>
<tr>
<td>Caldwell</td>
</tr>
<tr>
<td>Calloway</td>
</tr>
<tr>
<td>Carlisle</td>
</tr>
<tr>
<td>Christian</td>
</tr>
<tr>
<td>Crittenden</td>
</tr>
<tr>
<td>619 N. 30th Street, Paducah, KY 42001 (270) 444-8183 (877) 444-8183 fax: (270) 444-8147</td>
</tr>
</tbody>
</table>

For more information contact the nearest Care Coordinator, or Vicki Johnson, Care Coordinator Program Administrator, (502) 564-6539 or (800) 420-7431.

Innovative Educational Services
To take the post-test for CE credit, go to: www.cheapceus.com

Create PDF files without this message by purchasing novaPDF printer (http://www.novapdf.com)
Community-Based Organizations

AIDS Interfaith Ministries of Kentuckiana (AIM) provides support services to individuals living with HIV/AIDS and their families in the Louisville area. (502) 574-6085 http://www.aimkyonline.org/

AIDS Services Center Coalition (ASCC) is a coalition of agencies whose primary goal is to direct the public to appropriate AIDS service agencies, literature distribution, and provide a HIV/AIDS resource directory. The agency has an extensive volunteer network. (502) 574-5490 www.ascncinc.org

AIDS Volunteers of Cincinnati (AVOC) located in Cincinnati, OH is a community-based organization that provides a wide variety of services to individuals diagnosed with HIV/AIDS and to the broader community, especially high-risk populations where HIV exposure is more likely. Although AVOC primarily serves Cincinnati and southwest Ohio, they offer many of their services to individuals and groups in Northern Kentucky. These services include community outreach, prevention and education presentations, street outreach to women in underserved communities, testing and counseling services, an informational and referral hotline and a speaker’s bureau. (513) 421-AIDS (2437) www.avoc.org

AIDS Volunteers of Northern Kentucky (AVNK), located in Florence, KY was founded in 1990. AVNK seeks to understand and address the emotional, educational, social, spiritual and physical needs of the people in Northern Kentucky and surrounding communities who are living with HIV/AIDS, and the needs of their families, partners, friends and caregivers. AVNK strives to inform the general community about HIV/AIDS related issues for purposes of education, mobilization, prevention and advocacy. AVNK provides a number of services including three support groups, a monthly dinner/social, healing weekends, respite care, emergency financial assistance, memorial services, outreach to minority communities, World AIDS Day services and Healing Weekends. (859) 512-7925 e-mail mconnelly@insightbb.com

AIDS Volunteers, Inc. (AVOL) located in Lexington is a community based organization that provides HIV and AIDS education, prevention initiatives, service programs and financial assistance to persons infected and affected by HIV disease in all of Central and Eastern Kentucky. Some of the services provided by AVOL include: a speakers’ bureau, support groups, financial assistance, case management, transitional housing for those who are homeless and HIV+, a community residence for those in the end stages of AIDS, community outreach, condom distribution, educational programs and materials, and prevention activities. Funding for AVOL comes from community donations, fund raisers and grants from private foundations, as well as local, state, and federal sources including HUD (HOPWA) and the United Way. Approximately 75-100 volunteers are consistently involved throughout the year for day to day operations, programs and services, volunteer caregivers and fundraising events. Program referrals and linkages are through the health departments, other volunteer organizations and HIV Care Coordinators. (859) 225-3000; Fax (859) 225-9244; http://sites.google.com/site/avolky/

American Red Cross (ARC) is located in nearly every county in Kentucky. The number of ARC employees range from one or two in the smaller communities to more than 300 in the Louisville Chapter. Budgets are also diverse, with smaller chapters having budgets of a few thousand dollars to in excess of a hundred thousand dollars in Lexington and Louisville. There is disparity in the provision of HIV/AIDS services among counties, with smaller, more rural counties believing that there is “no problem” in their community (thus no reason for services) to the larger, more urban chapters offering quite a range of services. HIV/AIDS services include the distribution of brochures, AIDS 101 training, peer training for adolescents, African American AIDS 101 training, Hispanic AIDS 101 training, and prison and church leader AIDS 101 training, and a program specifically entitled “AIDS in the Workplace” which is designated for businesses and industries. (502) 589-4450 http://www.louisville-redcross.org

Bluegrass Care Clinic (BCC), located in Lexington is a Ryan White CARE Act Part C grantee. The BCC provides both clinical and support services for HIV/AIDS patients and their affected families in 63 counties through Central and Eastern Kentucky. The BCC staff are trained to provide harm reduction information and counseling regarding drug use, sexual activity and other high risk activities for HIV transmission and infection. In addition, the BCC also provides pre/post test counseling and testing. (859) 323-5544; Fax: (859) 257-2040; www.mc.uky.edu/bluegrasscareclinic

Bluegrass Farmworker Health Center (BFHC): Located in Lexington and Richmond, the BFHC serves a primarily migrant/seasonal farmworker population in Fayette, Scott, Bourbon, Clark, Madison, Garrard, Jessamine and Woodford counties. Spanish is the primary language of approximately 96% of the BFHC clients. The BFHC strives to optimize clients’ health outcomes by providing affordable, culturally appropriate primary and preventive health care that is accessible to Spanish-speaking farmworkers and their families, especially for those in rural and underserved communities who are living with HIV/AIDS and to the broader community, especially high-risk populations where HIV exposure is more likely. Although BFHC primarily serves Lexington and Fayette counties, they also provide service to farmers in the surrounding areas. BFHC services include community outreach, prevention and education presentations, street outreach to women in underserved communities, testing and counseling services, an informational and referral hotline and a speaker’s bureau. (502) 6115 6085  http://www.hcares.org

Innovative Educational Services
To take the post-test for CE credit, go to: www.cheapceus.com
House of Ruth provides social, emotional and financial support to people living with HIV/AIDS in the Louisville/Jefferson County area. (502) 587-5080 http://www.houseofruth.net/

I.N.D.Y (I'm Not Dead Yet) Project founded in 1994 serves Northern Kentucky. INDY is an organization dedicated to the enhancement of life for individuals affected by HIV and AIDS by providing social outlet in a variety of environments and frameworks with one basic goal in mind: having fun! Members and sponsors attend and host picnics, movie nights, dinners, camping trips, art events and parties. The group is dedicated to the proposition that through the joy of celebrating life there is hope and healing, and celebration is best engaged through groups of likeminded individuals. (859) 512-7925 e-mail mconnelly@insightbb.com

Matthew 25 AIDS Services, Inc. located in Henderson is a Ryan White CARE Act Parts B and C and CDC Prevention PA04064 Grantee. They are a provider of primary health care to PW HIV and LWA, in Daviess, Henderson, Union and Webster counties. Services include medical case management and referral, a buddy program, literature, spiritual support and referral, a speakers’ bureau, support groups (positive, family and friends), transportation and case management for the education and community for medical professionals. Matthew 25 also distributes HOPWA funds and does counseling and testing for HIV (blood and oral testing). (270) 826-0200 www.matthew25clinic.org

Moveable Feast (MFL) is a nutritional support program, serving people living with HIV disease and their dependent children living in the Lexington/Fayette County area. Clients receive social support and a hot, freshly cooked dinner five days a week. MFL can also serve as a referral source to other ASOs in the region. All services are completely free of charge. (859) 252-2867; www.feastlex.org

North Central AHEC/HETC: The mission of the North Central AHEC is to promote healthy communities through innovative partnerships. This is accomplished by providing educational support services to health professions students and health care providers, community health education and programs to encourage health professions as a career choice.

In order to address HIV prevention in Kentucky’s growing Hispanic community, the Kentucky DPH has identified agencies providing other services to our Hispanic population and provided capacity building assistance to help these agencies provide HIV prevention activities including HIV antibody testing. North Central AHEC/HETC collaborates with Area Health Education Centers across the state who recruit individuals from Hispanic communities, provide training, and utilize them to conduct HIV prevention activities in their communities. AHECs in Lexington (covering 5 counties) and Covington (covering 4 counties) currently conduct outreach in Hispanic communities, provide HIV testing, and conduct two community level intervention (Juntos and Promotores de Salud). A third AHEC in Louisville conducts similar activities with African-American communities. North Central AHEC/HETC also collaborates with the Bluegrass Farmworker Health Center to provide additional outreach to migrant farm workers as well as testing. The Lexington and Covington AHECs as well as the Bluegrass Farmworker Health Center have been extremely helpful in providing interpreters and assisting Hispanic clients receive services from other service providers who lack Spanish speaking employees. http://www.nckyahec.org/

Owensboro Area HIV/AIDS Task Force, Inc. is a non-profit CBO funded by donations. This agency serves its clients with emergency financial assistance, transitional housing, and acts as an advocate with property owners, utility companies, Social Security, HOPWA and other community service agencies. Volunteers also provide community outreach services with HIV prevention and risk reduction programs to targeted populations and various communities, medical professionals and local organizations. Members of the Task Force are state certified pre and post-test counselors as well as certified to administer OraSure for HIV testing. Members are also certified to inspect potential housing for clients wishing to obtain HOPWA funding. The Task Force is a certified partner of the Balm in Gilead. A support group for PW HIV is in place. They act as a referral source to all the available assistance programs for clients. The Task Force has some HIV positive members who have made presentations at several high schools, a program describing the emotional, physical and financial stresses of being HIV positive. (270) 683-6018 www.owensboro-aids.org

Sisters and Brothers Surviving AIDS (SABSA) is a support group located in Louisville for all HIV positive people and their friends and family. SABSA provides education and emotional support specific to the needs of those living with HIV and more specifically to the needs of the African-American community. However, everyone is welcome regardless of gender, race, sexual orientation, creed, religion or ethnic background. (502) 231-3871 http://www.sabsonline.com/home.htm

The Salvation Army of Central Kentucky, located in Lexington, operates a free medical clinic. The medical clinic, operated by the University of Kentucky’s College of Medicine, provides exams and physical therapy, and HIV pre/post test counseling and testing. (859) 252-7706 http://www.salvationarmylex.org/

University of Cincinnati Hospital, Holmes Clinic located in Cincinnati, Ohio is the Infectious Disease Center for the University of Cincinnati Hospital. Holmes Clinic provides medical services to individuals diagnosed with HIV/AIDS and is funded primarily through Ryan White Part C funds. Holmes Clinic provides these services to individuals from several states, and a significant percentage of individuals diagnosed with HIV/AIDS and living in Northern Kentucky use Holmes Clinic for their infectious disease care. In addition, Holmes Clinic conducts partner testing for patients of the clinic. (513) 584-6977. The University of Cincinnati Emergency Room also has a grant to conduct HIV testing and counseling services with patients who are seen through the Emergency Room. This program targets high-risk individuals who receive their primary medical care through the Emergency Room. If an individual is diagnosed, a referral is made to Holmes Clinic. (513) 584-5700

Volunteers of America, Inc. (VOA) in Louisville provides HIV prevention education, focus groups, and risk reduction workshops to drug users, men, women, and youth at risk. The prevention services offered include pre-test and post-test counseling, factual information about reducing HIV risk factors associated with drug use and sexual behavior, alcoholism and drug abuse assessments, and referrals to HIV related and non-related resources as needed or by request. VOA also provides an AIDS Housing Integration Project, which offers technical assistance to shelters, housing providers, and housing developers to help establish and implement new housing programs for homeless and low-income persons with HIV/AIDS. VOA also holds provides case management services to people living with HIV. This includes intake and assessment, goal setting, conflict resolution, crisis intervention, referral to community services, emergency financial assistance, linkage to rental and utility assistance, entry into support groups, mental health and substance abuse counseling. (502) 635-1361 http://www.voa.org/

Westlake Primary Care, located in Columbia, provides information and educational AIDS material, prevention kits with condoms, confidential testing and pre and post-test counseling. 270-384-4764

Innovative Educational Services
To take the post-test for CE credit, go to: www.cheapceus.com

27
**WINGS Clinic** located in Louisville is a Ryan White CARE Act Part C grantee. WINGS provides both clinical and support services for HIV/AIDS patients and their affected families. This clinic project provides primary and infectious disease care, adult and pediatric nutrition services, adult support groups, social services, legal services, family & mental health counseling, as well as liaisons to community services. 502-852-5203
http://www.thewingsclinic.com/

**References**


CDC. 2008 compendium of evidence-based HIV prevention interventions.


Perinatal HIV Guidelines Working Group. Public health service task force 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 April 29, 2009; pp 1-90


HIV/AIDS – Kentucky

Post-Test

1. A person is considered to have AIDS when _____________.
   A. Their T-cell count is less than 200 cells per microliter of blood.
   B. Their blood tests positive for the presence of HIV-2 antibodies.
   C. Their CD4 count is greater than 1,200 cells per microliter of blood.
   D. Their blood tests positive for the presence of the HIV-1 virus.

2. Which of the following is NOT an HIV associated opportunistic infection?
   A. Esophogeal candidiasis
   B. Extrapulmonary coccidioidomycosis
   C. Nephrotic isoporiasis
   D. Extrapulmonary M. kansasii

3. Which of the following is TRUE regarding HIV testing?
   A. Screening tests typically have low sensitivity and high specificity.
   B. The most common screening test is an ELISA Test that measures HIV antibodies in the blood.
   C. The HIV Dipstick Test is a confirmatory test commonly used in many countries around the world.
   D. The Immunofluoresence Assay (IFA) is considered to be the “Gold Standard” for confirmation of positive screening results.

4. Which of the following is FALSE regarding the CDC’s opt-out testing recommendations?
   A. The CDC now recommends testing all health care patients for HIV regardless of their reported risk behavior.
   B. Screening should be voluntary and undertaken only with the patient’s knowledge and consent.
   C. A separate consent form for HIV testing is recommended.
   D. If a patient declines an HIV test, this should be documented in the medical record.

5. High concentrations of HIV can be found in _______.
   A. feces
   B. saliva
   C. vomit
   D. breast milk
6. The combination of which two drugs might be used in highly active antiretroviral therapy (HAART)?
   A. Zidovudine and Crixiva
   B. ddl and Viramune
   C. Indavir and Norvir
   D. AZT and Delvaridine

7. Which of the following is FALSE regarding HIV post exposure prophylaxis?
   A. Healthcare providers exposed to HIV should be evaluated and tested for HIV within hours of exposure.
   B. A basic two step drug regimen should be administered after all potential exposures.
   C. An expanded three drug regimen should be used for exposures that pose an increased risk for transmission.
   D. All of the above are true.

8. Per the Kentucky statutes, which of the following does NOT have a legal right to know another individual’s HIV positive test results?
   A. A patient who shares a hospital room with an HIV+ individual
   B. Member of a hospital’s Program Evaluation Committee
   C. A crime victim
   D. Foster parent of a minor

9. The Americans with Disability Act (ADA) provides protection against discrimination to which of the following?
   A. Individuals with asymptomatic HIV infection
   B. Uninfected individuals rumored to be HIV positive
   C. Uninfected individuals who have a relationship with someone who is HIV positive.
   D. All of the above

10. HIV testing followed by violation of confidentiality is an example of ______.
    A. Cultural insensitivity
    B. Discrimination
    C. Enacted stigma
    D. Moral determination