13. **Resistance testing** [ii] - entry into care, ART initiation or switch, treatment failure, or if clinically indicated. For treatment-naïve patients, if resistance testing was performed at entry into care, repeat testing is optional post-ART initiation; for patients with viral suppression who are switching therapy for toxicity or convenience, resistance testing will not be possible and therefore, is not necessary. Genotype conducted at entry into care, prior to start of antiretroviral (ARV) therapy and when failing therapy (HIV viral load ≥ 1,000)

14. **HLA-B*5701** [ii] - If considering start of abacavir and document in record carrying data forward to most current volume

15. **Tropism testing** [ii] – If considering use of CCR5 antagonist (HIV viral load must be ≥ 1000) or if clinically indicated. If performed, record carried forward to most current volume

16. **Basic chemistry** [ii] - entry into care, follow-up before ART every 6-12 months, ART initiation or switch, 2-8 weeks post-ART initiation, or if clinically indicated. Serum Na, K, HCO3, Cl, BUN, creatinine, glucose (preferably fasting). It is suggested to monitor phosphorus while on tenofovir; determination of renal function should include estimation of creatinine clearance using Cockroft & Gault equation[vii] or estimation of glomerular filtration rate based on MDRD equation

17. **ALT, AST, T. bili, D. bili** [ii] - entry into care, follow-up before ART every 6-12 months, ART initiation or switch, 2-8 weeks post-ART initiation, or if clinically indicated

18. **CBC w/ differential** [ii] - entry into care, follow-up before ART every 3-6 months, ART initiation or switch, 2-8 weeks post-ART initiation if a zidovudine-containing regimen, or if clinically indicated

19. **Fasting Lipid Profile** [ii] (12 hours fasting) – entry into care, follow-up before ART annually if normal, ART initiation or switch, consider 2-8 weeks post-ART initiation, every 6 months if abnormal or borderline at last measurement, every 12 months if normal at last measurement, or if clinically indicated

20. **Fasting Glucose** [ii] (12 hours fasting) – entry into care, follow-up before ART annually if normal, ART initiation or switch, every 3-6 months if abnormal or borderline at last measurement, every 6 months if normal at last measurement, or if clinically indicated

21. **Urinalysis** [ii] - entry into care, at time of ART initiation or change, every 6 months in patients with HIV-associated nephropathy, and every 12 months in patients on a tenofovir-containing regimen, or if clinically indicated[viii]

22. **Pregnancy test** [ii] (females) – if starting an efavirenz-containing regimen or if clinically indicated

23. **Hepatitis A Screening**[ix] - At initial screening, Hepatitis A total antibody (HAVAb) or IgG (not IgM). Unless Hepatitis C infected, may consider administering immunization when CD4 cell count greater than 200 cells/mm^3

24. **Hepatitis B Screening**[vi] - At initial screening, Hepatitis B core antibody (HBcAb) total or IgG (not IgM), Hepatitis B surface antibody (HBsAb), and Hepatitis B surface antigen (HBsAg). If HBsAg is positive, evaluate Hepatitis B Viral Load by DNA PCR, and obtain Hep Be Ag and Ab

25. **Hepatitis C Screening**[vi] - At initial screening, Hepatitis C antibody (HCVAb). If HCVAb is positive evaluate Hepatitis C (HCV) Viral Load, genotype, and include treatment plan in record; If negative and active Injection Drug User or other HCV risk factor, repeat HCVAb in 12 months; If there is an unexplained chronic LFT elevation, Hepatitis C viral load should be evaluated (even if HCVAb is negative)

26. **Syphilis, N. gonorrhoeae** (GC), **C. trachomatis** (Chlamydia) [x] - Screening should be performed at least annually for all sexually active patients, more frequently might be appropriate depending on individual risk behaviors, the local epidemiology of STDs, and whether incident STDs are detected by screening or by the presence of symptoms. For men who have sex with men (MSM) via Receptive anal intercourse - screen for rectal gonorrhea and Chlamydia. For men who have sex with men (MSM) via receptive oral intercourse - screen for pharyngeal gonorrhea (Chlamydia not recommended). For men who have sex with men (MSM) with multiple or anonymous partners, or have sex during , illicit drug use, or use methamphetamine, or have sex partners with these risk factors, screening is recommended at 3-6 month intervals.[xi] Assume that all adult patients are sexually active unless noted in history or progress note that patient denies being sexually active

27. **Prostate-specific antigen (PSA) Screening**[xii] (males) - Offered annually, beginning at age 50, to men who have at least a 10-year life-expectancy. For African American men and those with a first-degree relative (father, brother, son) who had prostate cancer at an early age (< 65y/o), this discussion should take place at age 45. For those with several first degree relatives with prostate cancer at an early age, screening should begin at age 40. Information should be provided to all men about what is known and what is uncertain about the benefits, limitations, and harms of early detection and treatment of prostate cancer so that they can make an informed decision about testing.

Immunizations/Treatments

28. **Influenza vaccination**[xi] - Offer TIV annually and document in record

29. **Pneumococcal polysaccharide (PPSV) vaccination**[xi] - Offer initial vaccination as close to HIV diagnosis as possible, and then 1 booster after 5-6 years. Document in record carrying data forward to most current volume

30. **Hepatitis A vaccination**[xi] - Offer vaccination if not immune. Assess for response 30 days after vaccination by performing Hep A antibody IgG or Hep A Total antibody. Document in record carrying data forward to most current volume

31. **Hepatitis B vaccination**[xi] - Offer vaccination if not immune. Double dose is recommended. Assess for response 30 days after vaccination by performing Hepatitis B surface antibody quantitative (Hep B SAb Quant). Document in record carrying data forward to most current volume

32. **Tetanus, diphtheria, pertussis (Td/Tdap)**[xiii] - Substitute 1-time dose of Tdap, for adults age 19-64 who have not received a dose of Tdap previously, for Td booster; then boost with Td every 10 yrs. Document in record carrying data forward to most current volume

33. **ARV therapy is considered and discussed** - If offered, the risks and benefits are discussed

34. **Treatment of opportunistic infections and prophylaxis for opportunistic infections** - specifically, but not limited to, Mycobacterium avium complex (MAC), Pneumocystis Carinii Pneumonia (PCP), and Toxoplasmosis (Toxo) prophylaxis per DHHS Guidelines[xiv]

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[i] Routine pelvic examination and cervical cytology screening. ACOG Committee Opinion No. 431. American College of Obstetricians and Gynecologists. Obstet Gynecol 2009;113:1190–3.

[ii] http://www3.niaid.nih.gov/topics/HIVAIDS/Understanding/Population+Specific+Information/womenHiv.htm Accessed July 22, 2009.

[iii] http://www.cancer.org/docroot/PED/content/PED_2_3X_ACS_Cancer_Detection_Guidelines_36.asp. Accessed July 21, 2009.

[iv] http://my.clevelandclinic.org/services/fecal_occult_blood_test/hic_fecal_occult_blood_test.aspx. Accessed July 22, 2009.

[v] Adult Prevention and Treatment of Opportunistic Infections Guidelines Working Group. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents. March 24, 2009. MMWR 2009; 58 (early release) pp 1-198. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr58e324a1.htm. Accessed July 21, 2009.

[vi] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. November 3, 2008; 1-139. Available at http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf. Accessed July 21, 2009. Page 6, Table 3.

[vii] http://www.clinicalculator.com/english/nephrology/cockroft/cca.htm. Accessed July 22, 2009.

[viii] For patients with renal disease, consult "Guidelines for the Management of Chronic Kidney Disease in HIV-Infected Patients: Recommendations of the HIV Medicine Association of the Infectious Diseases Society of America" (Clin Infect Dis 2005; 40: 1559-85).

[ix] http://www.aidsetc.org/pdf/workgroups/pcare/pcwg-heptools.pdf. Accessed July 21, 2009.

[x] *Counseling for Patients with HIV Infection and Referral to Support Services*, page 18, *Sexually Transmitted Diseases Treatment Guidelines, 2006*, http://www.cdc.gov/MMWR/PREVIEW/MMWRHTML/rr5511a1.htm. Accessed July 21, 2009

[xi] http://www.faetc.org/PDF/Newsletter/Newsletter-Volume10-2009/HIVCareLink-Vol10-Issue-5-April-15.pdf. Accessed July 22, 2009.

[xii] http://www.cancer.org/docroot/PED/content/PED_2_3X_ACS_Cancer_Detection_Guidelines_36.asp.

Accessed July 21, 2009.

[xiii] http://www.cdc.gov/vaccines/recs/schedules/downloads/adult/2009/adult-schedule-11x17.pdf. Accessed July 22, 2009.

[xiv] Adult Prevention and Treatment of Opportunistic Infections Guidelines Working Group. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents. March 24, 2009. MMWR 2009; 58 (early release) pp 1-198. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr58e324a1.htm. Accessed July 21, 2009.

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Miami-Dade County Ryan White Program
Oral Health Care Standards

Standard 1: Oral health care providers shall ensure that all staff have sufficient education, knowledge, skills and experience to competently serve the HIV/AIDS client population: initial orientation and training for new staff shall be provided and all staff shall participate in ongoing HIV/AIDS trainings.

	Standards of Care	Measure
Standard 1.1	All oral health care staff will possess appropriate licenses, credentials and expertise; experience working with HIV/AIDS clients is desirable.	Copy of current license for each staff person, with provider number, as required by Florida law: copies of current required operational licenses as required by Florida law. Documentation of work experience (letters of recommendation, work references, etc.)
Standard 1.2	Policies and procedures.	Written policies and procedures manuals.
Standard 1.3	Newly hired staff will receive orientation within one month of hire, including training on Ryan White Program eligibility and service requirements.	Documentation of completed orientation on file including documentation of training on Ryan White Program eligibility and service requirements.
Standard 1.4	Ongoing annual HIV/AIDS staff training.	Documentation of all completed annual trainings on file.

Standard 2: Clients receiving services meet Ryan White Program eligibility requirements and are informed of their rights per Ryan White Program.

	Standard	Measure
Standard 2.1	Ryan White Program client eligibility screening and demographics present.	Proof of HIV status, financial eligibility, permanent residency in Miami-Dade County OR Current (not > 6 mos.) Ryan White Program Certified Referral.

		Demographics include at a minimum: address, phone number, emergency information, age, race/ethnicity and gender.
Standard 2.2	Ryan White Program required documents present, signed and dated.	Signed and dated Consent to Release and Exchange Information in the SDIS OR current (not > 6 mos.) Ryan White Program Certified Referral; documentation that SDIS Notice of Privacy Practices was provided.
Standard 2.3	General Consent for Treatment	- Signed general consent for treatment present

Standard 3: All clients shall have a completed initial medical history with updates as appropriate; medical conditions and allergies are noted; an oral health history is taken.

	Standard	**Measure**
Standard 3.1	Initial Comprehensive Medical History	There is an initial comprehensive medical history including medications and conditions affecting diagnosis and management of oral health care. The initial comprehensive medical history is signed and dated by the client and dentist.
Standard 3.2	Medical History is updated as appropriate.	Medical history is updated every 6 months or at the next appointment after six months.
Standard 3.3.	Medical conditions and allergies are noted.	Medical conditions and/or medications requiring an alert are flagged. Allergies or NKA are noted.
Standard 3.4	An oral health history is taken.	Oral health history is taken that includes problems with or reactions to anesthesia, specific or chief complaints (if any), problems with previous treatment (if any).

Standard 4: Documentation across providers shall reflect, at a minimum, services provided, treatment plans, examinations, charting grids, informed consents, refusal of treatment and periodontal maintenance.

	Standard	Measure
Standard 4.1	Treatment assessment and planning.	Completed treatment plan is in the progress notes OR a treatment plan form is completed.* **If clients access oral health services for episodic care only, documentation in treatment notes will reflect clients were advised to return for examination and a treatment planning appointment. If client does not present for this appointment, documentation in client's chart of advice to return for planning may serve as treatment plan.*
Standard 4.2	Documentation reflects services provided.	Documentation, at a minimum, includes: Date of service Tooth number, if appropriate Service description Anesthetic used including strength and quantity Materials used, if any Prescriptions or medications dispensed, including name of drug, quantity and dosage Education provided Signature and title
Standard 4.3	A comprehensive examination is provided* *Not applicable for episodic care, follow up or problem focused examinations.	Comprehensive Examination includes: Cavity charting Complete periodontal exam or periodontal screening record

		Documentation of restorations & prosthesis Full mouth radiographs Pre-existent conditions Disease presence Structural anomalies Oral hygiene Instruction Prescriptions or medications Dispensed including name of drug, quantity and dosage Education provided
	OR	
	A problem-focused oral examination is performed.	Problem-focused examination includes: Chief complaint is documented Problem-focused evaluation is performed Prescriptions or medication Dispensed include name of drug, quantity and dosage Radiographs as necessary Specific oral treatment plan Education provided Return for further evaluation documented
Standard 4.4	Charting grids are completed as appropriate.	Charting of the examination findings/treatment is completed in the appropriate tooth grids.
Standard 4.5	Informed specific consents are present for each oral surgery procedure.	A signed, informed, specific consent is present for all oral surgery procedures that includes the risks, benefits, alternatives and consequences of not having the procedure.
Standard 4.6	Refusal of treatments/radiographs is documented.	Client refusal for treatment/radiograph is documented (form or in progress noted) with DDS signature, client signature or initials and date; <u>signature and date of witness are present</u>.

		Reason for DDS refusal to perform a requested treatment is documented; signature and date of witness are present.
Standard 4.7	Periodontal maintenance is regularly performed.* *Not applicable for clients who are "No shows" AND "No show" is documented; not applicable for episodic care.	Periodontal maintenance is performed according to the treatment plan or at the next appointment, if later than six months.

Standard 5: Client care and referrals shall be coordinated with other care providers, as appropriate.

	Standard	Measure
Standard 5.1	Treatment provided for oral opportunistic infection (when indicated) is coordinated with client PCP.* *Not applicable if no oral OI Dx/treatment documented.	Documentation reflects treatment provided for oral OI and coordination with PCP.
Standard 5.2	Referral and coordination of care.* *Not applicable if no condition documented and no referral made. Tobacco use and referral.* *NA for clients not using tobacco products. Nutritional problems and referral.* *Not applicable when no indication of nutritional problems.	Documentation in client record of the condition and referral to a specific specialty or ancillary service provider. Documentation of heavy tobacco use and referral to a tobacco counseling program. Documentation of nutritional problems and referral to a nutritionist for nutritional counseling.

Standard 6: Clients shall receive education in preventive health oral health practices; tobacco and nutritional counseling as appropriate.

	Standard	Measure
Standard 6.1	Education will be provided in preventive oral health practices[1] including hygiene, nutritional education[2] as related to oral health care and education, as appropriate, concerning tobacco use[3]. [1]Not applicable for episodic care. [2]Not applicable for episodic care. [3]Not applicable if no indication of tobacco use; not applicable for episodic care.	Documentation of education in preventive oral health practices including hygiene is provided every six months or at next appointment if later than six months. Documentation of nutritional education as related to oral health. Documentation of education, as appropriate, concerning tobacco use.

RYAN WHITE PROGRAM
TREATMENT GUIDELINES &
ADDITIONAL SERVICE DELIVERY STANDARDS

OUTPATIENT MEDICAL CARE (INCLUDING MINORITY AIDS INITIATIVE)

Guidelines: Providers will adhere to the following clinical guidelines for treatment of HIV/AIDS specific illnesses (which can be found at www.aidsinfo.nih.gov/guidelines/):

- Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents. Department of Health and Human Services. December 1, 2009; pp 1-161. Available at: http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf.

- Working Group on Antiretroviral Therapy and Medical Management of HIV-Infected Children. Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection. February 23, 2009; pp 1-139. Available at: http://aidsinfo.nih.gov/ContentFiles/PediatricGuidelines.pdf.

- 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. Available at: http://aidsinfo.nih.gov/ContentFiles/PerinatalGL.pdf.

- A Guide to Primary Care for People with HIV/AIDS, 2004 Edition, John G. Bartlett, M.D., et al, U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau; and Pocket Guide to Adult HIV/AIDS Treatment, February 2006 edition.

- A Guide to the Clinical Care with Women with HIV/AIDS, 2005 Edition, Jean Anderson, MD, U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau.

- Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents, Recommendations from the Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), and the HIV Medicine Association of the Infectious Diseases Society of America, Morbidity and Mortality Weekly Report (MMWR), April 10, 2009, vol. 58, No. RR-4.

OUTPATIENT MEDICAL CARE (INCLUDING MINORITY AIDS INITIATIVE) (continued)

- Guidelines for Prevention and Treatment of Opportunistic Infections among HIV-Exposed and HIV-Infected Children, Recommendations from the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), the HIV Medicine Association of the Infectious Diseases Society of America, the Pediatric Infectious Diseases Society, and the American Academy of Pediatrics, Morbidity and Mortality Weekly Report (MMWR), September 4, 2009, vol. 58, No. RR-11.

- Clinical Manual for Management of the HIV-Infected Adult, AIDS Education and Training Centers (AETC) National Resource Center, 2006 Edition, updated July 2007.

- Care and Treatment for Hepatitis C and HIV Co-infection, HIV/AIDS Bureau, April 2006; Available at http://hab.hrsa.gov/tools/coinfection/.

- Clinical Guide on Supportive and Palliative Care for People with HIV/AIDS, Alexander, Carla, MD; et. al., 2003 Edition.

- In addition, providers will adhere to other generally accepted clinical practice guidelines.

Standards:

- Providers will inform clients as to generally accepted clinical guidelines for HIV+ pregnant women, treatment of AIDS specific illnesses, clients infected with tuberculosis, hepatitis, or sexually transmitted diseases, and other priorities identified by the Miami-Dade HIV/AIDS Partnership's Medical Care Subcommittee.

- Providers will screen for TB and make necessary referrals for appropriate treatment. In addition, providers will follow Universal Precautions for TB as recommended by the CDC. Providers will also screen for hepatitis, sexually transmitted diseases, and other priorities identified by the Miami-Dade HIV/AIDS Partnership's Medical Care Subcommittee.

MENTAL HEALTH THERAPY/COUNSELING & PSYCHOSOCIAL SUPPORT SERVICES

Guidelines (Mental Health Therapy/Counseling Levels I and II; and Psychosocial Support Services Levels III and IV): Providers will adhere to generally accepted clinical guidelines for mental health therapy/counseling of persons with HIV/AIDS. The following are examples of such guidelines:

MENTAL HEALTH THERAPY/COUNSELING & PSYCHOSOCIAL SUPPORT SERVICES (continued)

- American Psychiatric Association (APA) Policies and Position Statements, and Resource Documents on AIDS and HIV Disease, including: *HIV Infection; HIV and Discrimination; Confidentiality, Disclosure, and Protection of Others; HIV Antibody Testing; Psychiatric Implications of HIV/HCV Coinfection; Recognition and Management of Substance Use Disorders and Other Mental Illnesses Comorbid with HIV; HIV Infection and Pregnant Women; HIV and Children; HIV and Adolescents; Needle Exchange Programs; Recognition and Management of HIV-Related Neuropsychiatric Findings and Associated Impairments; HIV-Infected Psychiatrists; Occupational HIV Exposure: Protocols and Protections; HIV & Crystal Methamphetamine; HIV Infection and People Over 50;* as well as *Outpatient Psychiatric Services*, American Psychiatric Association, Arlington, VA, 2003 through 2008, as may be amended.

- *Practice Guideline for the Treatment of Patients with HIV/AIDS,* American Psychiatric Association, Arlington, VA, November 2000; including *Guideline Watch: Practice Guideline for the Treatment of Patients with HIV/AIDS,* Marshall Forstein, M.D., et al, American Psychiatric Association, April 2006, as may be amended.

Guidelines (Pastoral Care): Providers will adhere to generally accepted clinical guidelines for pastoral care counseling of persons with HIV/AIDS. References for these guidelines include those issued by:

- *Association for Clinical Pastoral Education*
- *American Institute of Islamic Studies and Culture*
- *Canadian Association for Pastoral Practice and Education*
- *National Association of Catholic Chaplains*
- *National Association of Jewish Chaplains*

SUBSTANCE ABUSE TREATMENT/COUNSELING – RESIDENTIAL & OUTPATIENT (INCLUDING MINORITY AIDS INITIATIVE)

Guidelines: Providers will adhere to generally accepted clinical guidelines for substance abuse treatment of persons living with HIV/AIDS. The following are examples of such guidelines:

SUBSTANCE ABUSE TREATMENT/COUNSELING – RESIDENTIAL & OUTPATIENT (INCLUDING MINORITY AIDS INITIATIVE) (continued)

- Published by the American Society of Addiction Medicine (ASAM), these guidelines include principles for working with HIV-positive patients in addiction treatment settings including, but not limited to, HIV antibody testing, post-exposure prophylaxis (PEP) for HIV, integrating HIV-positive patients into addiction treatment programs and groups, neuropsychiatric components of HIV/AIDS, approaching the medical evaluation in the era of HIV/AIDS, and harm-reduction strategies in addiction medicine (*Guidelines for HIV Infection and AIDS in Addiction Treatment,* American Society of Addiction Medicine, Melvin Pohl, M.D., Chair, et al, Chevy Chase, MD, most current as of March 1, 2010; and the *Principles of Addiction Medicine*, Fourth Edition).

- Published by the ASAM, national guidelines were developed for the implementation of a patient placement system. The purpose of this clinical guide is to place the patient in a level of care that has the appropriate resources to treat the patient's condition [*ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders (ASAM PPC-2R)*, American Society of Addiction Medicine, Washington, DC, Second Edition-Revised (April 2001)].

- Published by the ASAM, public policy statements (see www.asam.org/policycategory.cfm) related to the substance abuse treatment of clients living with HIV/AIDS, that include *Access to Sterile Syringes and Needles (formerly "Needle Exchange"), Hepatitis C (with Physician Supplement), HIV/AIDS Education for Drug and Alcohol Treatment, HIV Testing of Patients in Addiction Treatment Facilities, Primary Medical Care for HIV Infected Patients in Addiction Treatment, and The Treatment of Patients With Alcoholism or Other Drug Dependencies, and Who Have or are at Risk for Acquired Immunodeficiency Syndrome (AIDS)*, 1994-2003.

- Rules governing the treatment of physically drug dependent newborns, substance exposed children, and/or children adversely affected by alcohol and the families of these children that are consistent with the administrative regulations promulgated in Chapter 65 of the Florida Administrative Code by the State of Florida Department of Children and Family Services, as may be amended.

- Rules governing the provision of substance abuse treatment services consistent with the regulations promulgated by the State of Florida's Alcohol Prevention and Treatment (APT) and Drug Abuse Treatment and Prevention (DATAP) programs, as may be amended.

SUBSTANCE ABUSE TREATMENT/COUNSELING – OUTPATIENT & RESIDENTIAL (INCLUDING MINORITY AIDS INITIATIVE) (continued)

- Rules governing the provision of residential and outpatient substance abuse treatment services with regards to licensure and regulatory standards that are consistent with the administrative regulations promulgated in Chapter 65D-30, Substance Abuse Services, of the Florida Administrative Code by the State of Florida Department of Children and Families, as may be amended.

HOME DELIVERED MEALS

Guidelines:

- Providers will adhere to generally accepted nutritional standards for provision of meals to persons living with HIV or AIDS. One accepted clinical practice guideline is provided by The American Dietetic Association, *Manual of Clinical Dietetics*, that includes recommended allowances and a sample menu and daily meal plan for a high-protein, high calorie diet, commonly used for HIV infected individuals who are protein and energy malnourished (*Manual of Clinical Dietetics*, 6th Edition, co-published by The American Dietetic Association and the Dietitians of Canada, © October 2000, including the supplement of June 2001 and the errata update of September 2002).

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