Blood/Body Fluid Exposure and Anonymous Source Testing - Creating a Streamlined Process

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September, 2018
Objectives

01  Occupational Exposure an Historical Overview

02  Understanding Confidential vs Anonymous Source Patient

03  Pediatric Source Patient Testing

04  The Ryan White Act

05  Creating a parallel Occupational Exposure Process

06  Key Policy Contents for Blood/Body Fluid Exposure Process
“The best way to find yourself is to lose yourself in the service of others.”

“Mahatma Gandhi”

**Healthcare Personnel (HCP)** are defined as all paid and unpaid persons working in healthcare settings who have the potential for exposure to patients and/or blood or other body fluids.
Occupations Affected by Bloodborne Infectious Diseases

✓ Health Care Personnel
✓ First Responders/Emergency Response Personnel
✓ Correctional Health Care Workers
✓ Maintenance and Waste Workers
✓ Tattoo Artist

The potential exists for blood and body fluid exposure to other workers, and the same principles of exposure management could be applied to other settings and personnel.

✓ Students
✓ Contractors
✓ Public-safety workers
✓ Hospital Volunteers
✓ Law enforcement
Inception of Occupational Exposures
## Occupational Exposure to Bloodborne Pathogens
### Historical View

1991 the bloodborne pathogens standard was drafted by OSHA- 29 CFR part 1910.1030 to ensure employees in every state will be protected under general performance-oriented standards.

Primary purpose is to assure so far as possible, safe and healthful working conditions for every American worker over the period of his or her working lifetime.

Adopted by 23 states and 2 territories:

<table>
<thead>
<tr>
<th>States</th>
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</thead>
<tbody>
<tr>
<td>Alaska</td>
<td>Minnesota</td>
<td>Vermont</td>
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<tr>
<td>Arizona</td>
<td>Nevada</td>
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<td>California</td>
<td>New Mexico</td>
<td>Virgin Islands</td>
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<td>Connecticut</td>
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<td>Hawaii</td>
<td>North Carolina</td>
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<td>Indiana</td>
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<td>Iowa</td>
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<td>Kentucky</td>
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<td>Maryland</td>
<td>Tennessee</td>
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<td>Michigan</td>
<td>Utah</td>
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</table>
State by State HIV Testing in Occupational Exposures

Currently there are 36 states with laws that allow unconsented HIV testing of source patients in select cases of occupational exposures when such exposures occurs to healthcare personnel rendering care in the hospital setting.

<table>
<thead>
<tr>
<th>Testing source patients in cases of occupational exposure between Source Patient and Health Care Provider (as of April 2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laws compatible with unconsented testing of source patients</td>
</tr>
<tr>
<td>Laws incompatible with unconsented testing of source patients or no specific occupational exposure statute available</td>
</tr>
</tbody>
</table>
States with Defined Occupational Exposure Testing Laws

Require a court order for all instances of unconsented testing

- Arizona
- Maine
- New Mexico
- Oregon

Permits unconsented HIV testing in cases of occupational exposure only if source patient lacks capacity to consent, comatose, & unable to reach next of kin, OR deceased.

- Hawaii
- Maryland
- New York

Permits unconsented HIV testing on source patients with full capacity even if they refuse voluntarily testing

- California
- South Carolina
- Rhode Island
Exposures
Most Common Exposure Injuries

Types of injuries that can place HCP at risk for HBV, HCV, or HIV infections are:

**Percutaneous Injury**
1. Needlestick
2. Cut with a sharp object
3. Bite

**Non-Intact Skin or Mucous Membranes**
1. Exposed skin that is chapped
2. Abraded
3. Afflicted with dermatitis
Body Fluids

Blood and body fluids containing visible blood, semen and vaginal secretions are considered potentially infectious.

The following fluids also are considered potentially infectious:

**High Risk:**
- Cerebrospinal fluid
- Synovial fluid
- Pleural fluid
- Peritoneal fluid
- Pericardial fluid
- Amniotic fluid

**Low risk:** *(not considered potentially infectious unless they contain blood)*
- Feces
- Nasal secretions
- Saliva
- Sputum
- Sweat
- Tears
- Urine
- Vomitus

Although semen and vaginal secretions have been implicated in the sexual transmission of HBV, HCV, and HIV, they have not been implicated in occupational transmission from patients to HCP.
Risk of Acquiring

The risk of transmission of HBV and HCV from an occupational exposure is significantly greater than the risk of HIV transmission

<table>
<thead>
<tr>
<th>Source</th>
<th>Risk</th>
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<tbody>
<tr>
<td>HBV</td>
<td></td>
</tr>
<tr>
<td>HBeAg+</td>
<td>6.0% - 30.0%</td>
</tr>
<tr>
<td>HBeAg-</td>
<td>1.0% - 6.0%</td>
</tr>
<tr>
<td>HCV+</td>
<td>1.8%</td>
</tr>
<tr>
<td>HIV+</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

“Raising the Bar”

Achieving Healthcare Safety Excellence!
**EDUCATE**

Healthcare personnel should be trained in the recognition and timely reporting of blood and body fluid exposure at the time of hire or matriculation (for students) to prevent delay in evaluation and care post-exposure.

Re-education annually

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**SCREEN**

Pre-vaccination serological testing (HBsAg and HBsAb) for HBV

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**VACCINATE**

- Full series of HBV vaccine
- Immunity should be documented by testing for anti-HBs 1–2 months after completion of the series.
- Post vaccination anti-HBs titers >10 mIU/mL are considered evidence of seroprotection and no further testing is required for immunocompetent HCP.
- An additional dose of vaccine should be given to those with lower titers and repeat antibody testing performed 1–2 months later.
- Non-responders should receive two additional doses with repeat testing after the last dose.

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**DECLINATION**

As required by OSHA, individuals refusing vaccination must sign a statement confirming their refusal. This is not binding, however; individuals may opt for vaccination at a later date.
Creating a Comprehensive Exposure Program:

✓ Inventory for compliance gap analysis
✓ Collaborative team: Infection Prevention, EHS, and others as identified
✓ Stakeholder engagement of site leadership from EHS, Infection Prevention, Nursing, Emergency Medicine and Laboratory services
✓ Ownership of the exposure program should be clearly delineated
✓ Steps to the exposure process can be easily updated
✓ Create comprehensive protocols and specific workflows
✓ Steps to the exposure process should be easily accessible to all
✓ Occurrence reporting process
✓ Employee exposure tracking and follow-up process
✓ Educational sessions to all levels (staff, leadership) and all shifts to ensure compliance, safety and quality
Employee Post Exposure Process

WHEN A HEALTHCARE WORKER IS EXPOSED TO A PATIENT’S BLOOD OR INFECTIOUS BODY FLUIDS TIME IS OF THE ESSENCE!
Step by Step Employee Post Exposure Process

**EXPOSURE**
- Immediately wash the area with soap and water, mucous membranes should be irrigated with tap water or normal saline.

**REPORTING**
- Inform your Manager or their designee of the incident. Also inform them if the source patient was exposed to your blood or body fluids as well.

**CARE**
- Reports to Emergency Department (ED) as soon as possible or at least within 30 minutes after the exposure. Baseline blood work.

**RESULTS**
- Remain in the ED until results of the source patient rapid HIV testing is available and considerations for prophylaxis has been reviewed. 1st dose of PEP offered.

**FOLLOW-UP**
- Complete incident report. The ED will give discharge and follow up instructions (follow up with EHS within 2-3 business days).
Important Points for Health Care Personnel
Exposure

Federal law requires covered employers to ensure that all medical evaluations and procedures, vaccines and post-exposure prophylaxis are made available to the employee within a reasonable time and at a reasonable location at no cost to the employee*

CDC and DOH recommendations:
1. When a potential occupational exposure to HIV occurs, every effort should be made to initiate Antiretroviral therapy (PEP), as soon as possible, ideally within the first 2 hours reduces the risk of seroconversion by 81%
2. First dose of PEP should be offered to the exposed worker while the evaluation is underway.
3. Decisions regarding initiation of PEP beyond 36 hours post exposure should be made on a case-by-case basis with the understanding the diminished efficacy when timing of initiation is prolonged
4. Persons who have responsibility for providing PEP may need expert advice and consultation.

The following resources are available:
The Clinical Education Initiative CEI PEP Line at 1-866-637-2342. When using the PEP Line, providers from New York State should identify themselves as such.

Baseline and Follow-Up

• Baseline
  - HIV testing of the exposed worker should always be obtained after an occupational exposure, even if the exposed worker declines PEP.

• Report
  - Complete occurrence report

• Counsel
  - A negative baseline test is the only way to show seroconversion following an occupational exposure
  - Expert consultation i.e. OB-GYN

• Follow-Up
  Regardless of whether the exposed worker accepts or declines PEP treatment
  • Repeat HIV testing at 4 weeks and 12 weeks
  • A negative HIV test result at 12 weeks post-exposure reasonably excludes HIV infection related to the occupational exposure; routine testing at 6 months post-exposure is no longer recommended (NYSDOH)
# NYSDOH and CDC Recommendations

<table>
<thead>
<tr>
<th>Regulatory Body</th>
<th>Number of Drugs in PEP Regimen</th>
<th>Duration of PEP</th>
<th>HIV Antibody Testing of Healthcare Worker</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CDC Recommendations (2013):</strong>&lt;br&gt;A three-drug PEP regimen is the preferred option for all significant-risk occupational exposures</td>
<td>Tenofovir disoproxil fumarate 300 mg PO daily + Emtricitabine 200 mg PO daily <em>plus</em> Raltegravir 400 mg PO twice daily</td>
<td>4 weeks</td>
<td>Baseline&lt;br&gt;4 weeks post-exposure&lt;br&gt;12 weeks post-exposure&lt;br&gt;6 months post-exposure&lt;br&gt;Alternatively, if the clinician is certain that a fourth-generation antibody/antigen combination assay is being used, then HIV testing could be performed at baseline, 6 weeks, and concluded at 4 months post-exposure.</td>
</tr>
<tr>
<td><strong>NYSDOH AI Recommendations (2014):</strong>&lt;br&gt;A regimen containing three (or more) antiretroviral drugs is recommended for all occupational exposures. Clinicians facing challenges associated with a three-drug regimen might consider a two-drug regimen in consultation with an expert</td>
<td>Tenofovir disoproxil fumarate 300 mg PO daily + Emtricitabine 200 mg PO daily <em>or</em> Lamivudine 300 mg PO daily <em>plus</em> either Raltegravir 400 mg PO twice daily <em>or</em> Dolutegravir 50 mg PO daily</td>
<td>4 weeks</td>
<td>Baseline&lt;br&gt;4 weeks post-exposure&lt;br&gt;12 weeks post-exposure</td>
</tr>
</tbody>
</table>
### Recommended Hepatitis B Prophylaxis Guidelines

<table>
<thead>
<tr>
<th>Infection status of the source</th>
<th>Vaccination and/or antibody response status of exposed person&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Treatment when source patient is:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HBsAg positive</td>
<td>HBsAg negative</td>
</tr>
<tr>
<td>Unvaccinated/ non-immune</td>
<td>HBIG&lt;sup&gt;b&lt;/sup&gt; x 1; initiate HBV vaccine series</td>
<td>Initiate HBV vaccine series</td>
</tr>
<tr>
<td>Previously vaccinated,&lt;sup&gt;c&lt;/sup&gt; known non-responder&lt;sup&gt;d&lt;/sup&gt;</td>
<td>No treatment</td>
<td>No treatment</td>
</tr>
<tr>
<td>Previously vaccinated,&lt;sup&gt;c&lt;/sup&gt; known non-responder&lt;sup&gt;d&lt;/sup&gt;</td>
<td>HBIG&lt;sup&gt;b&lt;/sup&gt; x 1; and initiate revaccination&lt;sup&gt;e&lt;/sup&gt; or HBIG&lt;sup&gt;b&lt;/sup&gt; x 2</td>
<td>No treatment</td>
</tr>
<tr>
<td>Previously vaccinated,&lt;sup&gt;c&lt;/sup&gt; antibody response unknown</td>
<td>Single vaccine booster dose</td>
<td>No treatment</td>
</tr>
<tr>
<td>If still undergoing vaccination</td>
<td>HBIG&lt;sup&gt;b&lt;/sup&gt; x 1; complete series</td>
<td>Complete series</td>
</tr>
</tbody>
</table>

HBsAg, hepatitis B surface antigen; HBIG, hepatitis B immune globulin; anti-HBs, antibody to hepatitis B surface antigen.

<sup>a</sup> Persons who have previously been infected with HBV are immune to re-infection and do not require PEP.

<sup>b</sup> Dose 0.06 mL/kg intramuscularly.

<sup>c</sup> Vaccinated with full three-dose series.

<sup>d</sup> Based on information available at presentation. Responder is defined as person with previously documented adequate levels of serum antibody to HBsAg (serum anti-HBs >10mIU/mL); non-responder is a person with previously documented inadequate response to vaccination (serum anti Hbs <10mIU/mL). It is not recommended that decision-making be delayed while testing for anti-HBs at presentation.

<sup>e</sup> The option of giving one dose of HBIG and re-initiating the vaccine series is preferred for non-responders who have not completed a second three-dose vaccine series. For persons who previously completed a second a second three-dose vaccine series. For persons who previously completed a second vaccine series but failed to respond, two doses of HBIG are preferred.

<sup>f</sup> High-risk is defined as sources who engage in needle-sharing or high-risk sexual behaviors, and those born in geographic areas with HBsAg prevalence of >2%.36
Confidential Source vs. Anonymous Source
Patient Testing
Rapid HIV Testing Onsite

Rapid HIV testing of the source patient is mandated for occupational exposures in organizations that are subject to OSHA regulations.

✓ Rapid HIV testing is a requirement, results must be readily available within one hour.

✓ Organizations and agencies that perform Rapid HIV Testing must be registered as a limited service laboratory with the NYSDOH Clinical Laboratory Evaluation Program (CLEP).

✓ Policies and procedures must be developed to ensure compliance with NYS public health law and regulations as well as FDA requirements and manufacturer's recommendation for test performance.
Anonymous Source Patient Testing - are done on the source patients for HIV, Hepatitis B and Hepatitis C; that cannot be tied back to the source patient.

**Important Points:**

- The name of the source patient is never included in the results.
- Results is shared only with the clinician treating the exposed HCP ONLY for the purposes of determining their treatment plan.
- If source patient recovers, you can inform them an HIV test was performed, and offer testing without cost.
Elements for Anonymous Source Patient Testing

New York State regulations allow anonymous testing in the event of an occupational exposure.

- Occupational exposure occurs
- Source patient is - comatose, lack mental capacity, deceased
- Unit notified to collect source patient labs
- Source patients healthcare agent who has legal authority to consent not immediately available
- Exposed employee will benefit medically by knowing the source patients HIV test results
Confidential Source
Patient Testing
Confidential Testing

Consenting update:
Effective November 2016, written or oral consent for HIV testing is no longer required in any setting.

At a minimum patients must be orally informed that HIV testing is going to be performed and have the right to decline.

**Important points during oral information:**

- What is HIV
- Treatments for HIV/AIDS
- Test can be done anonymously
- Confidentiality of test results
- Law prohibits discrimination based on HIV results

*HIV testing remains voluntary and patients have the right to refuse HIV test, if the patient refuses to be tested, this must be noted in the patient’s medical record.

**Documentation of conversation:** Must be made in patients chart, language that can be used “Patient notified an HIV test is being performed” or a drop down box in EMR for providers to ‘check’ patient notified an HIV test is being performed or patient declined.
Confidential Testing

**Confidential Source Patient Testing** - are done on the source patient for HIV, Hepatitis B and Hepatitis C, patients are alert and orient and have the capacity to be informed that an HIV test will be performed.

**Important Points:**

✓ Source patient can refuse to have test performed

✓ The confidential results of these tests have the name of the source patient

✓ The results are shared with the clinician treating the exposed healthcare worker **ONLY** for the purposes of determining their treatment plan

✓ The results are shared with the source patient, information for treatment and follow-up is provided if applicable
Confidential Source Patient Testing

(Patient Agrees to be Tested)

Occupational Exposure Occurs

Supervisor, sends employee to the ED, and begins **Source** patient collection process

Patient orally informed of HIV testing

Source patient has capacity to be informed of HIV test

Collect Patient Blood

Free of charge to the patient

HIV rapid results sent to ED clinician treating the exposed HCP

Communication

Results also sent to physician treating source patient

Results
Confidential Source Patient Testing
(Patient Refuses to be Tested)

Occupational Exposure Occurs

Consent

Source patient has capacity

Testing

Supervisor Notified

Source patient refuses to have testing performed

STOP

Supervisor, sends employee to the ED, and begins source patient collection process

No further action for the source patient. HCP proceeds to ED for baseline screening and evaluation and determination for PEP.
Pediatric Source
Patient Testing
Must providers obtain parental consent to test an individual under 18 years old?

In New York State, the capacity to consent to an HIV test (either confidential or anonymous) is determined without regard to age.

• Providers offering HIV testing must make a determination as to the patient’s capacity to be informed that HIV testing is going to be conducted.
• If a provider determines a person under 18 years old does not have the capacity to be informed that HIV testing is going to be conducted:
  • Parent or other person authorized is informed

*Capacity to be informed is Required and is Not Based on Age Alone* The capacity to be informed is defined in the Public Health Law as the: "ability, determined without regard to the individual's age, to understand and appreciate the nature and consequences of a proposed health care service, treatment, or procedure, or of a proposed disclosure of confidential HIV related information, as the case may be, and to make an informed decision concerning the service, treatment or disclosure." (Public Health Law Section 2780.5).
Ryan White Comprehensive AIDS Resources Emergency (CARE) Act
Ryan White Act

Enacted August 18, 1990, in honor of Ryan White, an Indiana teenager who contracted AIDS through a tainted hemophilia treatment in 1984, and was expelled from school because of the disease. White became a well-known advocate for AIDS research and awareness, until his death on April 8, 1990.
The Ryan White CARE Act

The act mandates that EMS personnel can find out whether they were exposed to life-threatening diseases while attending, treating, assisting or transporting a victim.

**Diseases covered by the exposure notification guidelines:**

- Infectious pulmonary tuberculosis
- Hepatitis B
- HIV, including AIDS
- Diphtheria
- Hemorrhagic fevers
- Meningococcal disease
- Plague
- Rabies

- The receiving medical facilities must have in place procedures for responding to written requests from designated officers regarding the determination of exposure to the diseases covered under this Act.

- The receiving health care facility must have a designated officer within the health care facility to respond to ERE request for source patient results within the 48 hour window.

- Your local public health agency must also have in place procedures for handling requests for exposure incident evaluation from designated officers.
Figure 2. Emergency response employee requests information about possible exposure to listed disease.

**Emergency Response Employee (ERE)**

- Transports Victim

  - Requests determination of whether ERE was exposed to listed disease

**Designated Official**

- Collects facts & determines if exposure to listed disease may have occurred
  - NO: Sends facts to medical facility & requests determination of whether exposure to a listed disease occurred
  - YES: See Figure 3

**Medical facility treating victim and/or determining cause of death**

- Reviews facts submitted by Designated Official & clinical information about victim
  - Exposure Determination
    - No exposure
    - No diagnostic information
  - Finds facts about exposure submitted by Designated Official to be insufficient

- Notifies Designated Official within 48 hours

- Notifies Designated Official within 48 hours

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1. The Public Health Officer of each State designates a Designated Official of each employer of emergency response employees to receive employee requests, collect information, and provide notifications.
2. If a treating medical facility receives a request related to a victim who has died and the cause of death was determined by a different medical facility, the treating facility should send a copy of the request to the facility determining cause of death, which becomes responsible for responding.
3. If the medical facility subsequently determines that the victim of an emergency had a listed disease, it shall notify the Designated Official within 48 hours of the new determination.
Occupational Exposure
Parallel Management
Putting All Together
Parallel Process for Occupational Exposure Management

Step 1
HCP washes area and reports exposure to Immediate supervisor

Step 2
HCP reports to the ED, and evaluated for PEP

Step 3
HCP remains until source Pt rapid HIV results is available

Step 4
HCP reports to EHS within 2-3 business days after exposure

Step 2
HCP supervisor is ensuring source patient bloodwork is completed and sent to lab

Step 3
Rapid HIV for the source patient is completed, result given to ED clinician (1 hour)

Follows-up as directed
Policy Content
Blood and Body Fluid Exposure Policy

Putting It all Together

**Procedures/Guidelines**
- Health Care Personnel Process
- Source Patient Testing Process
  - Confidential
  - Anonymous
- Ambulatory Site Process
- Emergency Response Employees

**Roles and Responsibilities**
- Emergency Department
- EHS
- Nursing Leadership/Designee
- Laboratory
- HIV Specialist
- Hepatologist

**PEP Guidelines**
Most recent Post Exposure Prophylaxis (PEP) for HIV, Hepatitis B, and Hepatitis C

**EHS Process**
- Employee Follow Up care
- Exposure tracking system

**Occupational Exposure to Blood and Body Fluid Process Flowmap**
<table>
<thead>
<tr>
<th>Department</th>
<th>Role</th>
<th>Responsibilities</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ED</strong></td>
<td>Immediate Care of exposed HCW</td>
<td>Counseling, treatment and PEP according to NYSDOH guidelines</td>
<td>At time of Injury</td>
</tr>
<tr>
<td></td>
<td>Provide starter pack (7 days per guidelines) of PEP for rapid initiation and continuation of treatment upon discharge, with prescription given for balance of 28 day regimen</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>EHS</strong></td>
<td>Immediate Care (when indicated) and follow up for exposed HCW</td>
<td>Counseling, treatment, PEP, referrals and documentation according to regulatory guidelines</td>
<td>Within 3 days of injury</td>
</tr>
<tr>
<td><strong>ADN/ or designee</strong></td>
<td>Source Patient Laboratory Specimen Collection</td>
<td>Ensures source patient laboratory specimen is obtained immediately. Ensures Employee fills out occurrence report in Employee Self Service (ESS) or facility method of reporting</td>
<td>Upon notification of HCW exposure</td>
</tr>
</tbody>
</table>
| **Laboratory** | Source Patient Laboratory Specimen Processing and Results Notification | Notification of source patient results to source attending.  
• For HIV+ results: 3 attempts at verbal communication with hard copy sent  
• For HIV- results: hard copy sent | Upon receipt of laboratory requisition and upon lab results completion |
| **HIV Specialist** | Follow up PEP monitoring for exposed HCW | Provide best medical practice standards for exposed HCW including resistance HIV strains, medication changes, and managing exposure risk factors for HCW medical monitoring | Referral from EHS upon medical follow up of exposed HCW |
| **Hepatologist** | Monitoring of Hepatitis B and/or Hepatitis C exposure for exposed HCW | Best practice including prescribing medications for exposed HCW | Referral from EHS upon follow up of injured HCW |
### Recommended HIV PEP Guidelines

**Infection status of the source**

<table>
<thead>
<tr>
<th>Source patient</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV STATUS UNKNOWN</td>
<td><strong>Obtain consent for rapid HIV testing of source patient.</strong></td>
</tr>
<tr>
<td>Source tests NEGATIVE</td>
<td><strong>STOP PEP. PEP not indicated.</strong></td>
</tr>
<tr>
<td>Source tests POSITIVE</td>
<td><strong>HIV RNA POSITIVE</strong></td>
</tr>
<tr>
<td>Source patient does not have capacity to consent</td>
<td>See Footnote*</td>
</tr>
<tr>
<td>Source patient refuses HIV testing</td>
<td>See Footnote*</td>
</tr>
<tr>
<td>Source patient KNOWN TO BE HIV-INFECTED by medical record</td>
<td><strong>Offer exposed worker first dose of PEP while evaluation of exposure is underway.</strong></td>
</tr>
</tbody>
</table>

### COMPLETE 28-DAY REGIMEN:

**Recommended PEP Regimen**

- Tenofovir 300 mg PO qd
- Emtricitabine 200 mg PO qd
- Plus Raltegravir 400 mg PO bid or Dolutegravir 50 mg PO qd

- Perform baseline confidential HIV testing of the exposed worker and refer to experienced clinician within 3 days of initiating PEP.
- See Tables 4 and 5 for alternative regimens.

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* Depending on the test used, the window period may be shorter than 4 weeks. Clinicians should contact appropriate laboratory authorities to determine the window period for the test that is being used.

* If the source is known to be HIV-infected, information about his/her viral load, ART medication history, and history of antiretroviral drug resistance should be obtained when possible to assist in selection of a PEP regimen. Initiation of the first dose of PEP should not be delayed while awaiting this information unless results of resistance testing are pending. Upon receipt of these results, the PEP regimen may be modified if needed in consultation with an experienced provider.

* See Appendix A for dosing recommendations in patients with renal impairment.

* Lamivudine 300 mg PO qd may be substituted for emtricitabine. A fixed-dose combination is available when tenofovir is used with emtricitabine (Truvada 1 PO qd).

* See Appendix A for drug-drug interactions, dosing adjustments, and contraindications associated with raltegravir and dolutegravir.
## Key Things to Remember

<table>
<thead>
<tr>
<th>Decision</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time is of the Essence!</td>
<td>Designated regimen of antiviral medication should be started within 2 hours</td>
</tr>
<tr>
<td>Decisions regarding Initiation of PEP beyond 36 hours but no longer than 72 hours after the exposure are made on a cases by case basis with recognition of diminished efficacy</td>
<td></td>
</tr>
<tr>
<td>Pregnant healthcare Personnel should have OB consultation in the ED</td>
<td></td>
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<tr>
<td>Create a process in the event the patient is exposed to the HCP blood/body fluids</td>
<td></td>
</tr>
<tr>
<td>Employee results should be in a private domain only accessible by the occupational health providers</td>
<td></td>
</tr>
<tr>
<td>Source patient results are verbally given to the employee</td>
<td></td>
</tr>
</tbody>
</table>

*Northwell Health*
Resources

https://www.health.ny.gov/diseases/aids/providers/testing/rapid/samppro.htm


https://www.hivguidelines.org/pep-for-hiv-prevention/occupational/


Centers for Disease Control
Thank You

Questions