NEW HIV DIAGNOSIS – NOW WHAT?

January 28, 2026
Key Concepts:

- Initial evaluation and linkage to care for newly diagnosed individuals
- Strategies for initiating and maintaining ART
- Importance of adherence, follow-up, and viral load monitoring
- Interprofessional collaboration for comprehensive HIV care

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No financial interests to disclose

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HIV CARE CONTINUUM:

The series of steps a person with HIV takes from initial diagnosis through their successful treatment with HIV medication.

In 2022, an estimated **1.2 million people** had HIV.

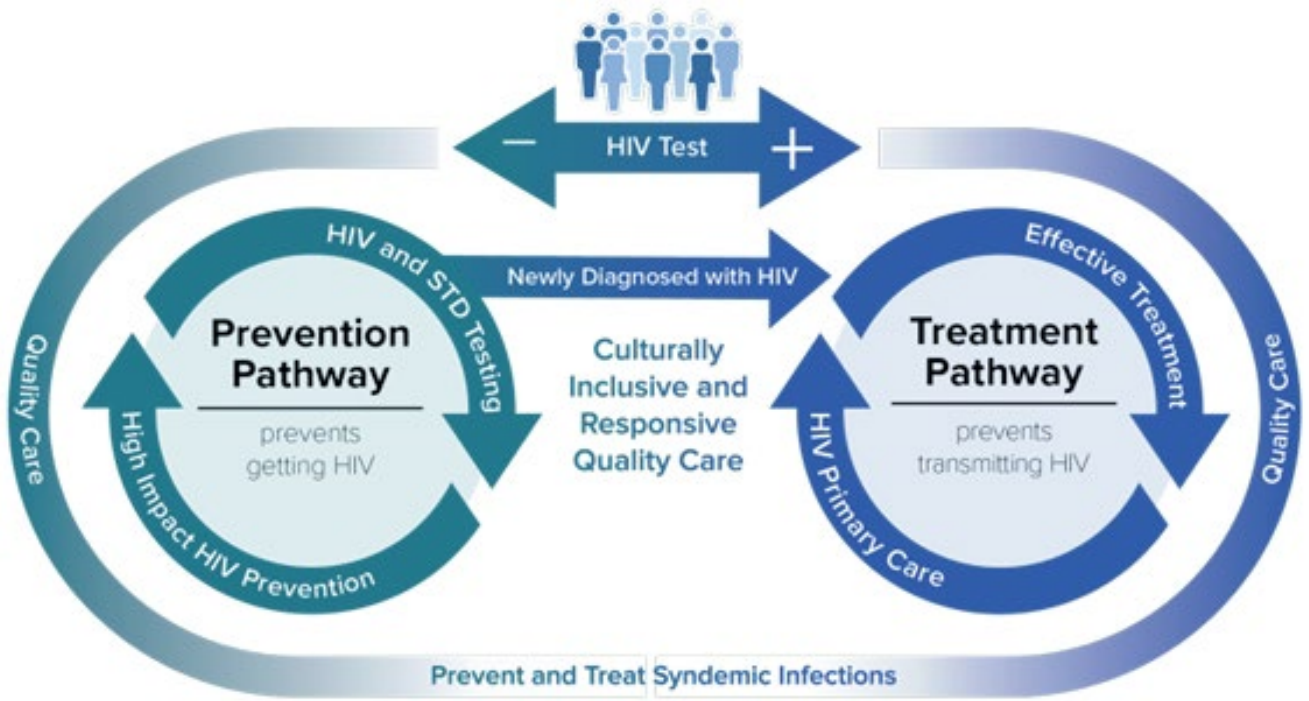
For every 100 people with HIV

87 knew their HIV status.

Ending the HIV Epidemic

Overall Goal: Increase the estimated percentage of people with HIV who have received an HIV diagnosis to at least 95% by 2025 and remain at 95% by 2030.

People whose HIV tests are negative are offered powerful prevention tools like PrEP, condoms, harm reduction, and supportive services to stay HIV negative.



People whose HIV tests are positive enter primary care and are offered effective treatment and supportive services to achieve and maintain viral suppression.

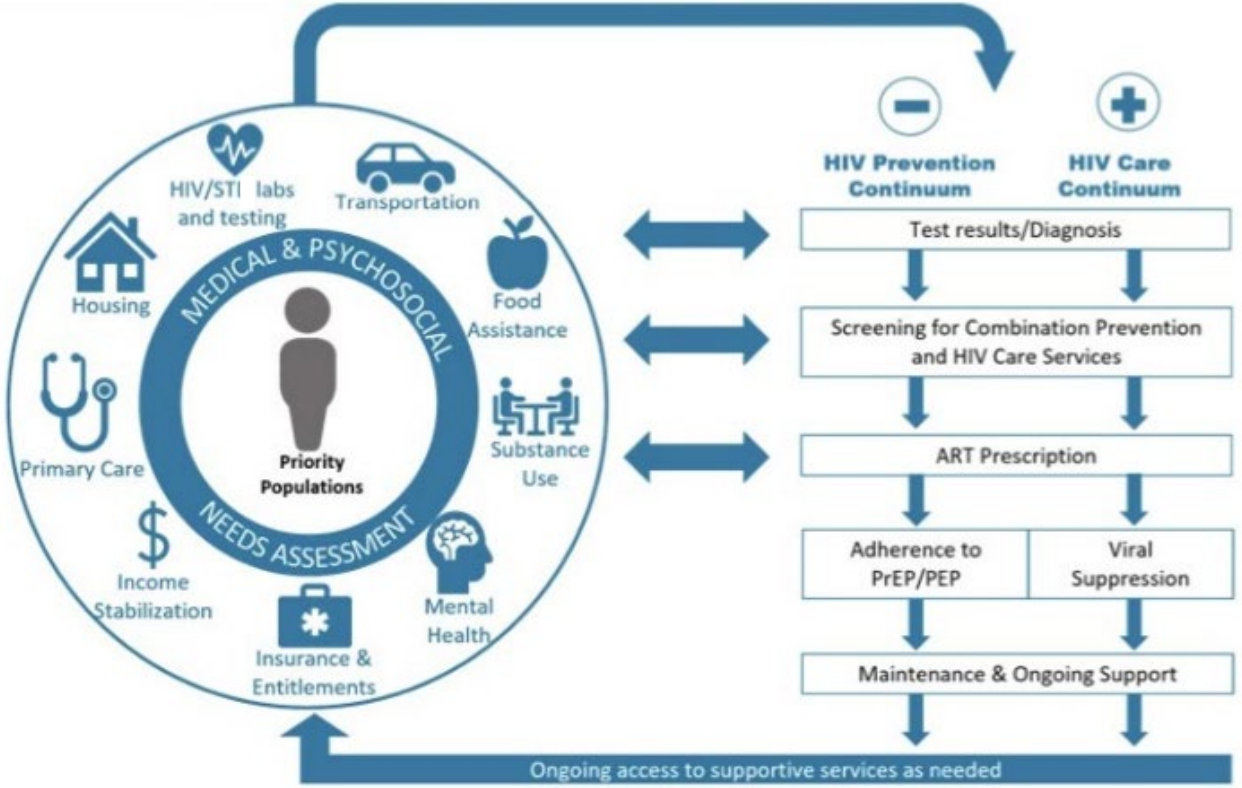
STATUS NEUTRAL HIV PREVENTION AND CARE

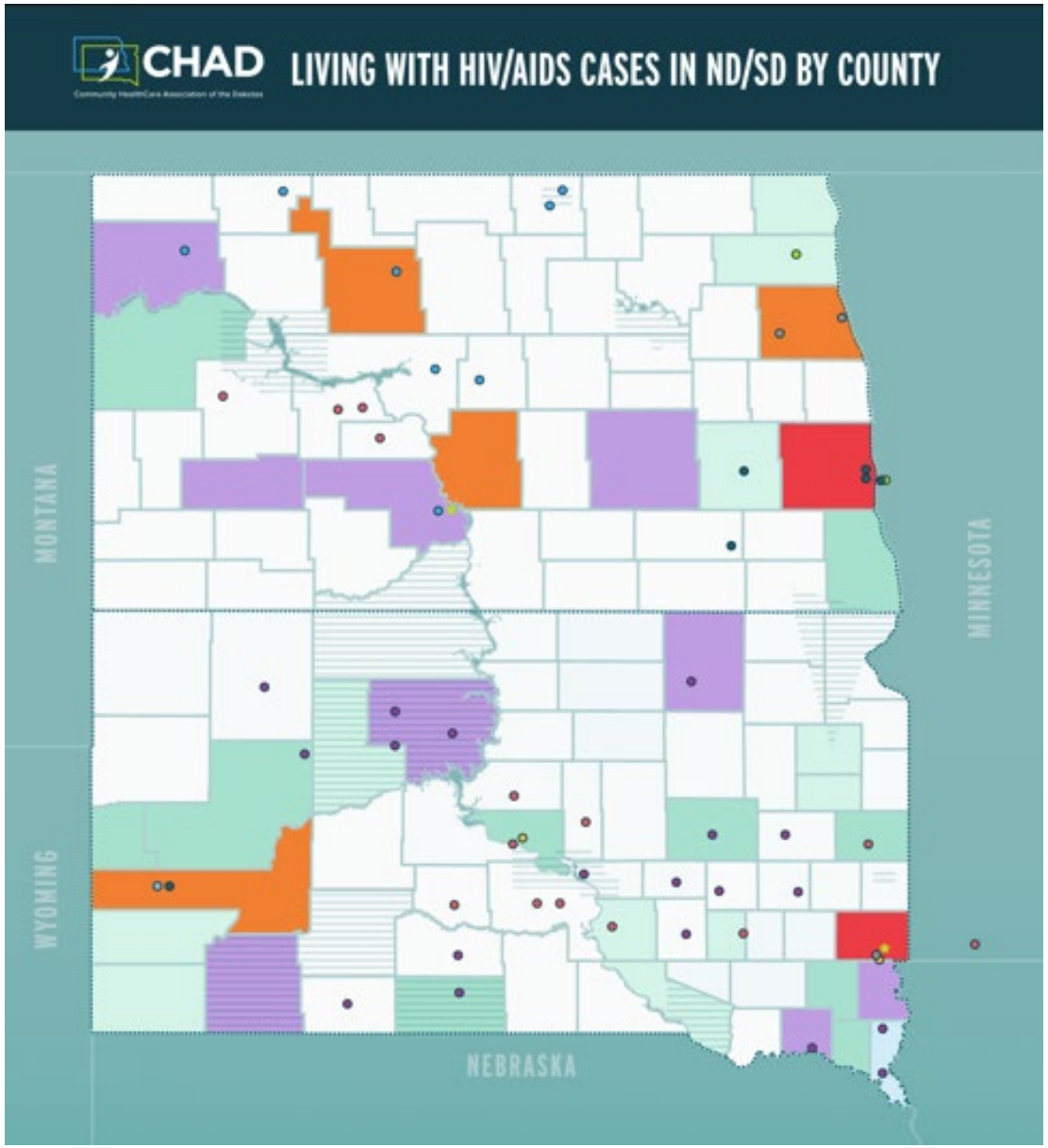
Follow CDC guidelines to test people for HIV. Regardless of HIV status, quality care is the foundation of HIV prevention and effective treatment. Both pathways provide people with the tools they need to stay healthy and stop HIV.

AIMS FOR STATUS NEUTRAL CARE

Follow CDC guidelines to test people for HIV

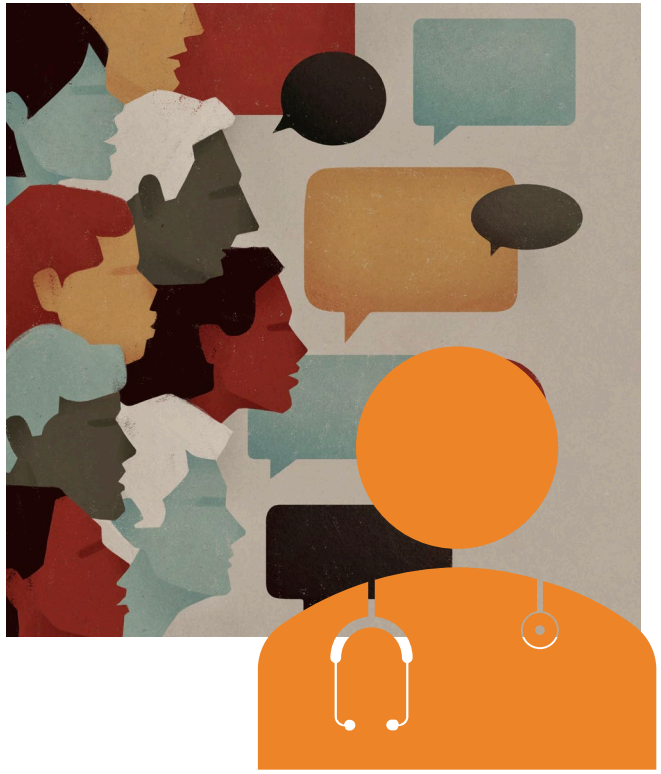
- Person-centered, "whole-person", respecting autonomy and person's health goals
- Improves accessibility for services
- Reduces stigma and biases
- Creates efficiencies
- Decreases new HIV infections





NORTH DAKOTA
SOUTH DAKOTA

BEFORE WE TALK TO OUR PATIENT:



- What type of test did they have?
- When was it completed?
- Did they have any factors making them vulnerable to HIV?
- Symptoms?
- Ever tested before?
- Comorbidities

TALKING WITH THE PATIENT **AFTER** THE CONFIRMATORY RETURNS POSITIVE

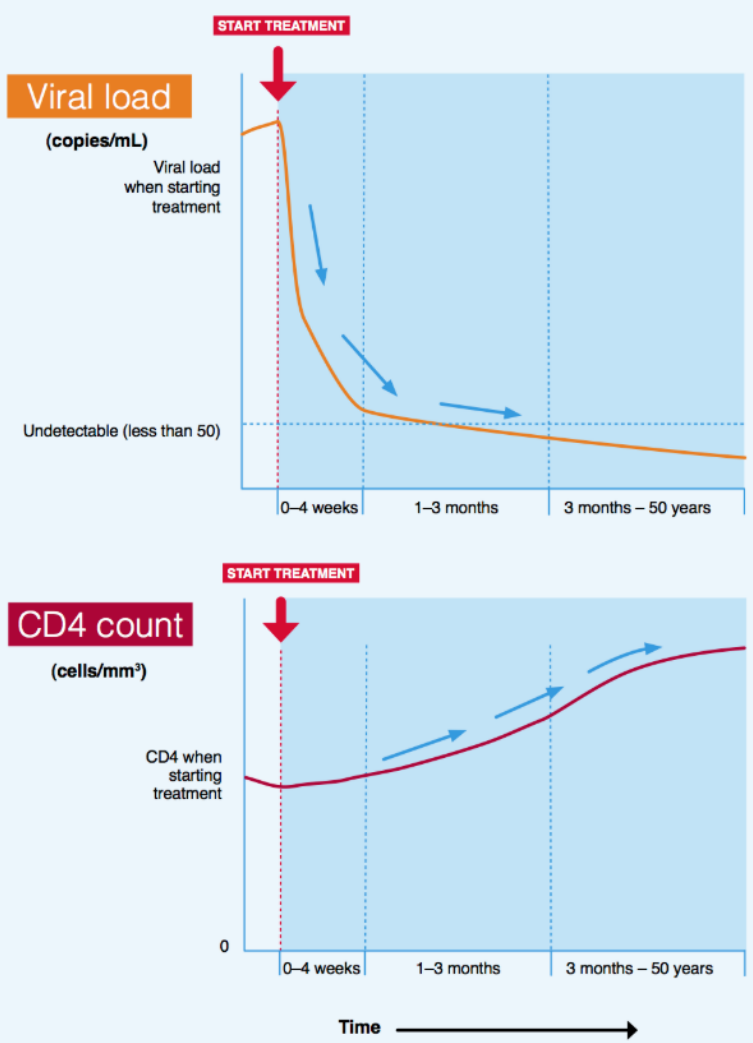
Explain	the goals for the visit – "today we will talk about"
Be	clear about the result. ... "This test confirms that your HIV test was positive."
Ask	the patient what they want, need, what questions they have
Emphasize	availability and importance of effective treatment
Explain	the process of partner notification
Know	state laws regarding disclosure
Link	to care – goal within 30 days

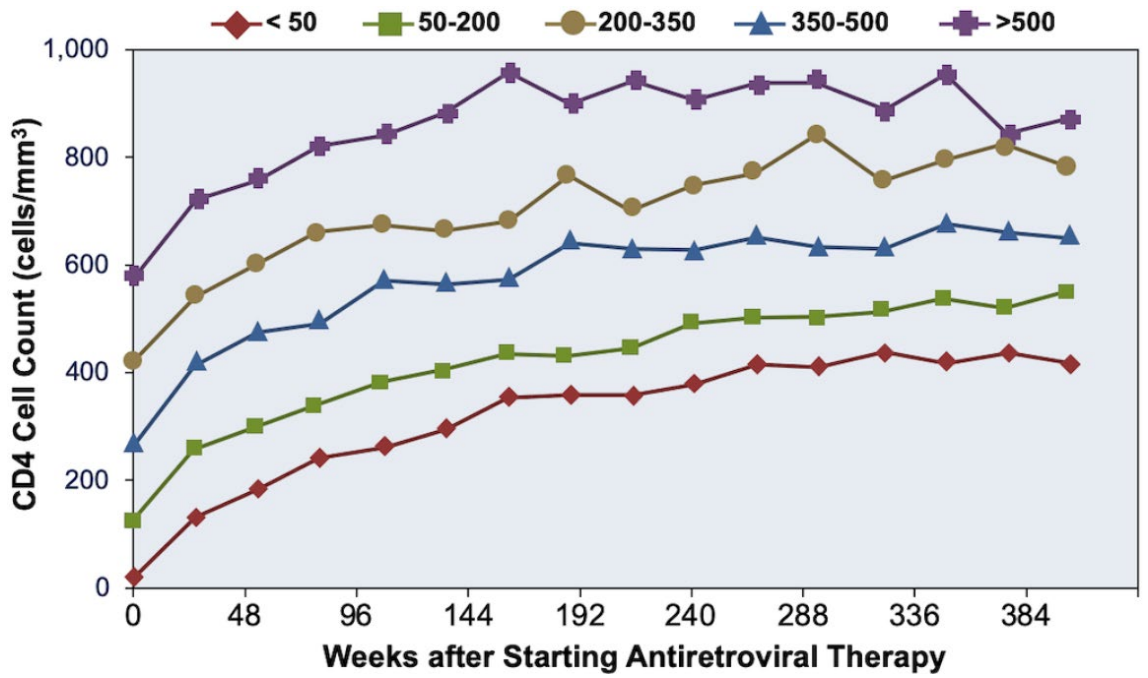
EXPLAIN "THE NUMBERS"

CD4 – How well your immune system is functioning (Normal 500 – 1200)

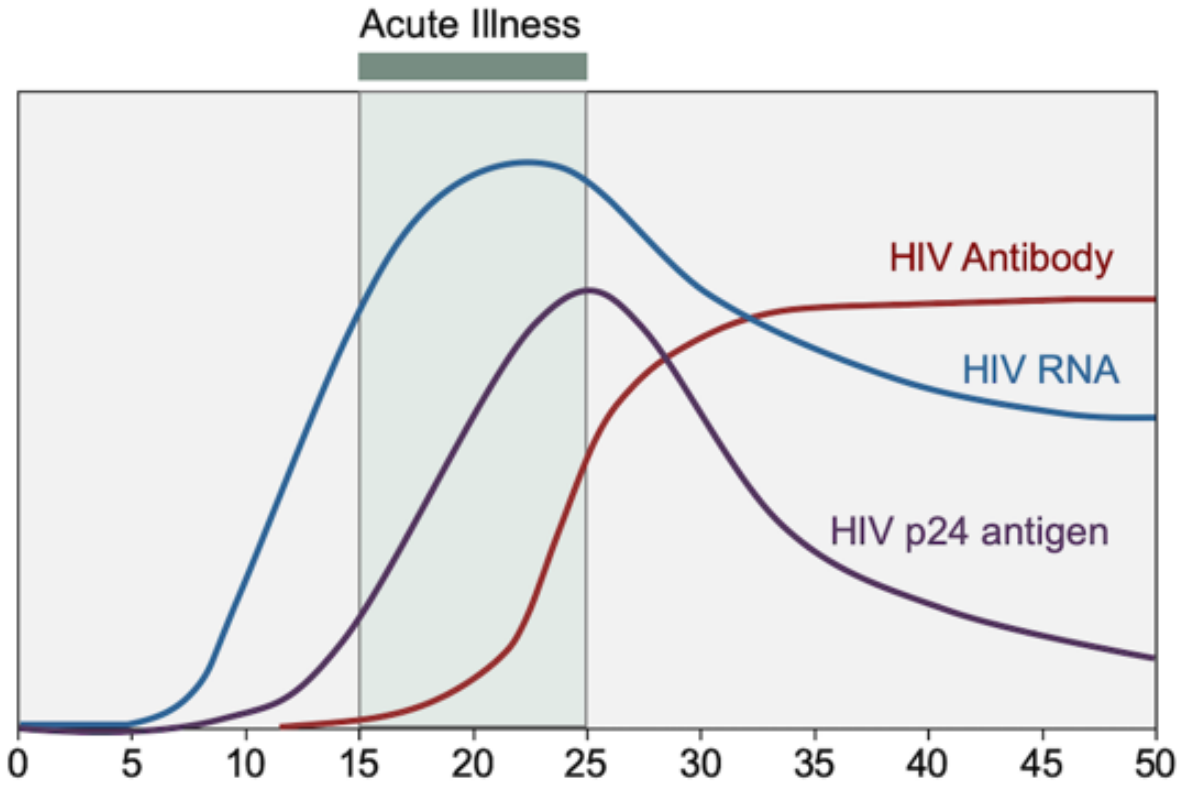
Viral Load – How much HIV is circulating per ml of blood

Typically, as the viral load increases, the CD4 decreases





CD4 IMPROVEMENT OVER TIME



DAYS FOLLOWING HIV ACQUISITION

SOURCE: UNIVERSITY OF WASHINGTON – NATIONAL HIV CURRICULUM

EXPLAIN ART

- Antiretroviral therapy (ART) is the medication we use to stop the virus from multiplying or reproducing.
- This keeps immune system from being damaged and allows it to recover
- It works so well that you may get to “undetectable.”

INITIATE ART AS SOON AS POSSIBLE AFTER DIAGNOSIS (SAME-DAY/RAPID ART)

- Benefits: Improved patient health outcomes (morbidity/mortality reduction) and decreased HIV transmission risk
- Baseline labs: Draw blood for all baseline tests (CD4, viral load, genotype, kidney function, etc.) before starting ART, but do not delay treatment while awaiting results.
- The only acceptable reason to delay ART is if the patient is not ready to commit to therapy.

ANSWERING DIFFICULT QUESTIONS:

"What is my prognosis?"

November 1990

David Kirby - Life Magazine

March 2019

First kidney donation from PLWH

ANSWERING DIFFICULT QUESTIONS:

HIV:

- There is HIV virus circulating in the blood stream
- HIV is the virus that causes AIDS - not everyone who acquires HIV will progress to AIDS

AIDS, defined by CDC as:

- CD4 count below 200
- AIDS-defining illnesses, opportunistic infections
  - Pneumocystis pneumonia (PJP/PCP)
  - Kaposi's Sarcoma
  - Candidiasis of esophagus, bronchi, trachea, lungs (not mouth)
  - Mycobacterium avium complex (MAC)
  - Many others

What is the difference between HIV and AIDS?

ANSWERING DIFFICULT QUESTIONS:

- The short answer is yes
- Most likely one pill one time per day
- Treatments are rapidly evolving, so your course may change over time
- Explain the benefits
  - Decreased complications
  - U=U
  - Lower side effect profile than prior treatments

Will I be on medication forever?

ANSWERING DIFFICULT QUESTIONS:

- **YES!**
- Recommend PrEP for partners if not undetectable
- Acknowledge the importance of individual comfort level
- Disclosing to partner(s) prior to sexual activity

Can I have sex?

ANSWERING DIFFICULT QUESTIONS:

- **YES! | Undetectable = Untransmittable**
- Stress the importance of achieving undetectable viral load before pregnancy whenever possible
- Mothers who take ART during pregnancy pose little to no risk of passing HIV onto their unborn children
- Fathers who are undetectable will not pass HIV through sperm

Can I have kids?

INITIAL WORK-UP

Baseline

- CBC
- CMP
- Hgb A1c
- TSH
- Hepatitis Panel | Hep B serology
- Vaccine titers – Varicella, MMR, Hep A, Hep B
- TB Gold
- EBV, CMV, Toxoplasmosis
- Lipid Panel
- Vitamin D
- Chlamydia, Gonorrhea, Syphilis
- Pregnancy Test

HIV Labs

- CD4
- Viral Load
- Genotype
- HLAB5701
- Tropism Testing

Health Maintenance

- Pap smear, Pelvic Exam
- Mammogram, CBE
- Colonoscopy
- Low Dose CT Scan
- Vaccine Updates
- Bone Density
- STI testing
- Mental Health Screening
- Substance Use Screening

Rapid ART

Starting antiretroviral therapy (ART) immediately after HIV diagnosis is recommended by U.S. federal guidelines. Rapid ART (aka immediate ART) can result in earlier HIV viral suppression, improved retention in care, and reduced HIV transmission.

INDICATIONS

Rapid ART is appropriate for:

- Individuals with a confirmed HIV diagnosis (i.e., HIV Ag, Ab, and/or HIV RNA viral load)
- Persons with suspected acute HIV infection, with or without confirmed HIV diagnosis (HIV Ag or Ab test results may be negative or indeterminate at the time of evaluation)

Rapid ART is not appropriate for:

- Persons with certain untreated opportunistic infections (OIs)—e.g., the CNS infections cryptococcal or TB meningitis; begin OI treatment before starting ART (consult with experts)

COMPRESSED HIV INTAKE

- Review of HIV test results
- Targeted health history
- HIV risk behaviors
- Date of last negative HIV test
- Use of PrEP or PEP
- Psychoemotional counseling, support
- HIV education (including ART benefits, possible adverse effects, adherence, preventing transmission)
- Targeted physical exam
- Benefits counseling, insurance enrollment or optimization

Baseline Labs

- Repeat HIV testing (if indicated)
- HIV RNA (quantitative viral load)
- CD4 cell count
- HIV genotype, including integrase
- HLA-B*5701
- CBC/differential
- Complete metabolic panel (kidney & liver tests, glucose)
- STI testing: syphilis test (RPR, VDRL, or treponemal), chlamydia and gonorrhea NAAT tests (urine, pharynx, rectum as indicated by sites of exposure)
- TB screening test (e.g., Quantiferon)
- Hepatitis serologies (HAV IgG, HBsAb, HBsAg, HBcAb, HCV IgG)
- Pregnancy test (if appropriate)

Offer ART

- If patient agrees and there are no contraindications, prescribe 30-day supply, give starter pack if available
- If patient declines immediate ART, follow up within 1-2 weeks, re-offer ART, continue HIV education

RECOMMENDED REGIMENS

These can be modified based on results of baseline labs.

- Dolutegravir (Tivicay), 50 mg once daily + [TAF/FTC (Descovy), TDF/FTC (Truvada), or TDF/3TC] 1 once daily
- Bictegravir/TAF/FTC (Biktarvy) 1 once daily
- Darunavir/cobicistat/TAF/FTC (Symtuza) 1 once daily

If **taking PrEP or PEP** at or since the time of HIV infection:

- Consider an enhanced regimen: boosted PI + integrase inhibitor + TAF/FTC (Descovy), TDF/FTC (Truvada), or TDF/3TC; seek consultation
- If on injectable cabotegravir PrEP, consider boosted PI + TAF/FTC (Descovy), TDF/FTC (Truvada), or TDF/3TC

If **pregnant** or trying to conceive (some antiretrovirals are notrecommended during pregnancy):

- Dolutegravir (Tivicay), 50 mg once daily + [TAF/FTC (Descovy), TDF/FTC (Truvada), or TDF/3TC] 1 once daily
- Other options may be appropriate; consult with expert

Abbreviations: 3TC: lamivudine; FTC: emtricitabine; PI: protease inhibitor; TAF: tenofovir alafenamide; TDF: tenofovir disoproxil fumarate; BID: twice daily

FOLLOW UP

Schedule a follow-up visit for 1-2 weeks, then at least monthly until well established in care

RESOURCES / REFERENCES

- **AETC National Clinician Consultation Center** Monday–Friday 9 AM to 8 PM ET / 800-933-3413
- See **full Rapid ART guide** at https://aidsetc.org/rapid-art
- Based on: Getting to Zero San Francisco. **Rapid ART: Immediate ART initiation at HIV diagnosis and re-engagement in care at:** www.gettingtozerosf.org

AIDS Education and Training Center Program. January 2023. AIDSETC.org

ANTIRETROVIRAL THERAPY

Treatment is prevention

Earlier viral suppression

Low barrier, open access model of care

Improves linkage and retention in care

Supports early and ongoing adherence

Now considered a Standard of Care

RAPID ART INITIATION

Candidate Criteria:

- New reactive HIV test, confirmed HIV, or suspected acute HIV
- ART-naive or limited prior ART
- No conditions requiring ART deferral (e.g., cryptococcal, TB meningitis, CMV retinitis)
- Perform baseline labs; ART can start while awaiting results (A3)

PROTOCOL FOR RAPID ART INITIATION

ART can be started while awaiting laboratory test results

Identify Rapid ART Candidates	Assessment, Counseling, and Referrals	Baseline Lab Testing	Payment Assistance	Initiate ART	Follow-up
Candidates have: ▪ A new reactive POC HIV test result, new HIV diagnosis, known or suspected acute HIV, or known HIV, *and* ▪ No or limited prior ARV use (except PEP/PrEP), *and* ▪ No known medical conditions or OIs that require deferral of ART initiation	▪ Assess health literacy ▪ Discuss HIV diagnosis and disclosure ▪ Discuss ART benefits, adherence, adverse effects, and management ▪ Identify and address medical and psychosocial barriers to treatment and adherence ▪ Refer for substance use treatment, behavioral health services, and housing assistance, as needed	▪ HIV Ag/Ab test ▪ Viral load ▪ Resistance testing ▪ CD4 count ▪ HAV, HBV, and HCV testing ▪ Metabolic panel ▪ STI testing (including syphilis) ▪ Urinalysis ▪ Pregnancy test for individuals of childbearing potential	▪ Assess need for payment assistance ▪ Refer patients with no insurance a Certified Application Counselor or Navigator ▪ Provide resources for sliding fee and/or payment assistance	▪ Choose among preferred regimens based on patient characteristics and preference ▪ Initiate ART immediately – preferably on the same day – or within 72 hours ▪ Administer the first dose on-site if possible	▪ Contact the patient within 24 to 48 hours by phone (or other preferred method) ▪ Assess medication tolerance and adherence ▪ If feasible, schedule in-person visit with medical care provider within 7 days ▪ Reinforce adherence ▪ Change or adjust the initial ART regimen as needed based on results of initial lab and/or resistance testing

RECOMMENDATIONS:

Rationale for Rapid ART Initiation:

- Recommend ART for all patients diagnosed with HIV (A1)
- Offer rapid ART – same day preferred, within 72 hours if eligible (A1)
  - Confirmed HIV diagnosis (A1)
  - Reactive screening, confirmatory pending (A2)
  - Acute HIV infection: Ab-negative, RNA-positive (A2)
- Counsel patients with HIV-negative partners on reduced transmission risk once virally suppressed; strongly recommend ART (A1)
- Involve patients in ART decisions; patient decides timing/initiation (A3)
- If patient declines rapid ART, revisit as soon as possible
- Initiate ART in advanced HIV/AIDS even with adherence barriers; refer to specialized support (A2)
- Monitor response or consult HIV specialist after initiation (A2)

Rapid ART initiation, the standard of care, is safe, effective, and widely accepted; even patients facing substance use, mental health, or housing should be offered immediate ART, with counseling and support services addressing potential adherence barriers.

MEDICAL HISTORY CHECKLIST

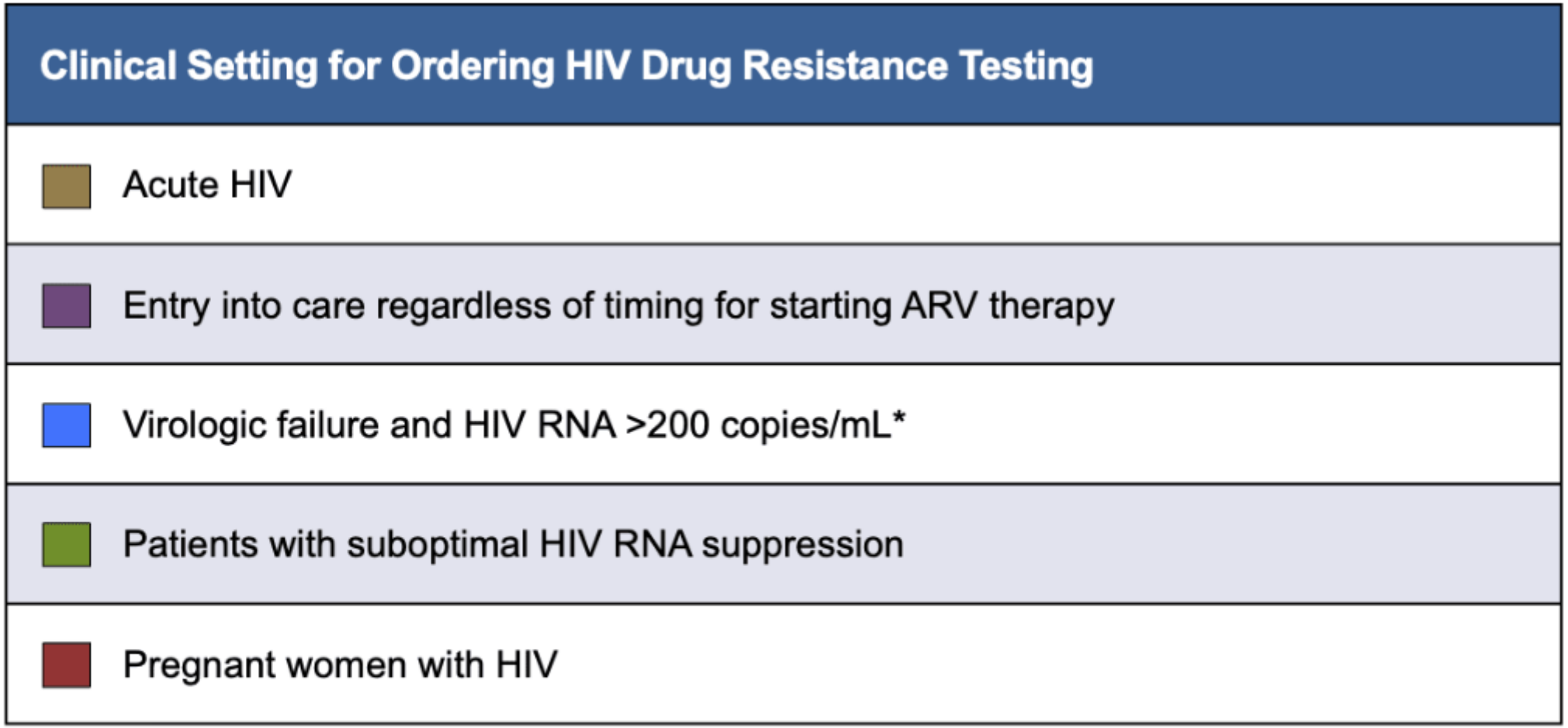
Before Rapid ART Initiation, Ask About:

- Date and result of last HIV test
- Serostatus of sex partners and their ART regimens *(if known)*
- Prior use of antiretrovirals, including PrEP or PEP *(with dates)*
- Comorbidities, especially renal or liver disease and hepatitis B
- Current prescribed and OTC medications
- Drug allergies
- Substance use
- Symptoms concerning for – cryptococcal meningitis, TB meningitis, and CMV retinitis
  - Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV
- Psychiatric history, including depression, psychosis, or suicidality
- Possible pregnancy and reproductive plans *(if applicable)*

BASELINE LABORATORY TESTING CHECKLIST

- ❑ HIV-1/2 Ag/Ab immunoassay
- ❑ HIV quantitative viral load test
- ❑ Baseline HIV genotypic resistance profile
- ❑ Baseline CD4 cell count
- ❑ Testing for hepatitis A, B, and C viruses AND hepatitis B immunity
- ❑ Comprehensive metabolic panel (creatinine clearance, hepatic profile)
- ❑ Pregnancy test for individuals of childbearing potential
- ❑ Urinalysis
- ❑ Syphilis, gonorrhea, and chlamydia screening as per

CDC Sexually Transmitted Infections Treatment Guidelines, 2021



*HIV-RNA levels >200 copies/mL but <500 copies/mL, drug-resistance testing may be unsuccessful but should still be considered.

Figure 12 - Indication for HIV Drug Resistance Testing
The Adult and Adolescent ARV Guidelines recommend performing routine HIV drug resistance testing in the situations shown in this figure.

Source: Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV. Department of Health and Human Services. Laboratory testing: drug-resistance testing. September 21, 2022.

SEPTEMBER 2025 HHS GUIDELINES UPDATE

Suboptimal CD4 Recovery Despite Virologic Suppression

- Updated evidence on clinical consequences of suboptimal CD4 recovery, including increased risk of AIDS and non-AIDS events and mortality
- Early diagnosis and prompt ART initiation provides maximal CD4 recovery
- To date, there is no effective therapeutic intervention to improve CD4 count for people with suboptimal CD4 recovery
  - *Interventions not recommended: changing ART, intensifying ART, interleukin-2*
- Focus on preventive care, modifiable risk factors, management of comorbidities

Clinicalinfo.hiv.gov - guidelines

SEPTEMBER 2025 HHS GUIDELINES UPDATE

Other Lab Testing Updates

- When to include an integrase resistance test at baseline:
  - If transmitted integrase resistance suspected, history of cabotegravir PrEP, *or history of integrase inhibitor use for PEP*
- When to include an integrase resistance test at treatment failure:
  - If history of integrase inhibitor use for treatment or *prevention*
- HBV serology panel:
  - Entry into care *plus repeat if switching off TAF or TDF if non-immune*

Clinicalinfo.hiv.gov - guidelines

NEW AND REVISED STATEMENTS ABOUT INITIATION OF ART

Acute/early infection:

start as soon as possible

New diagnosis in hospital:

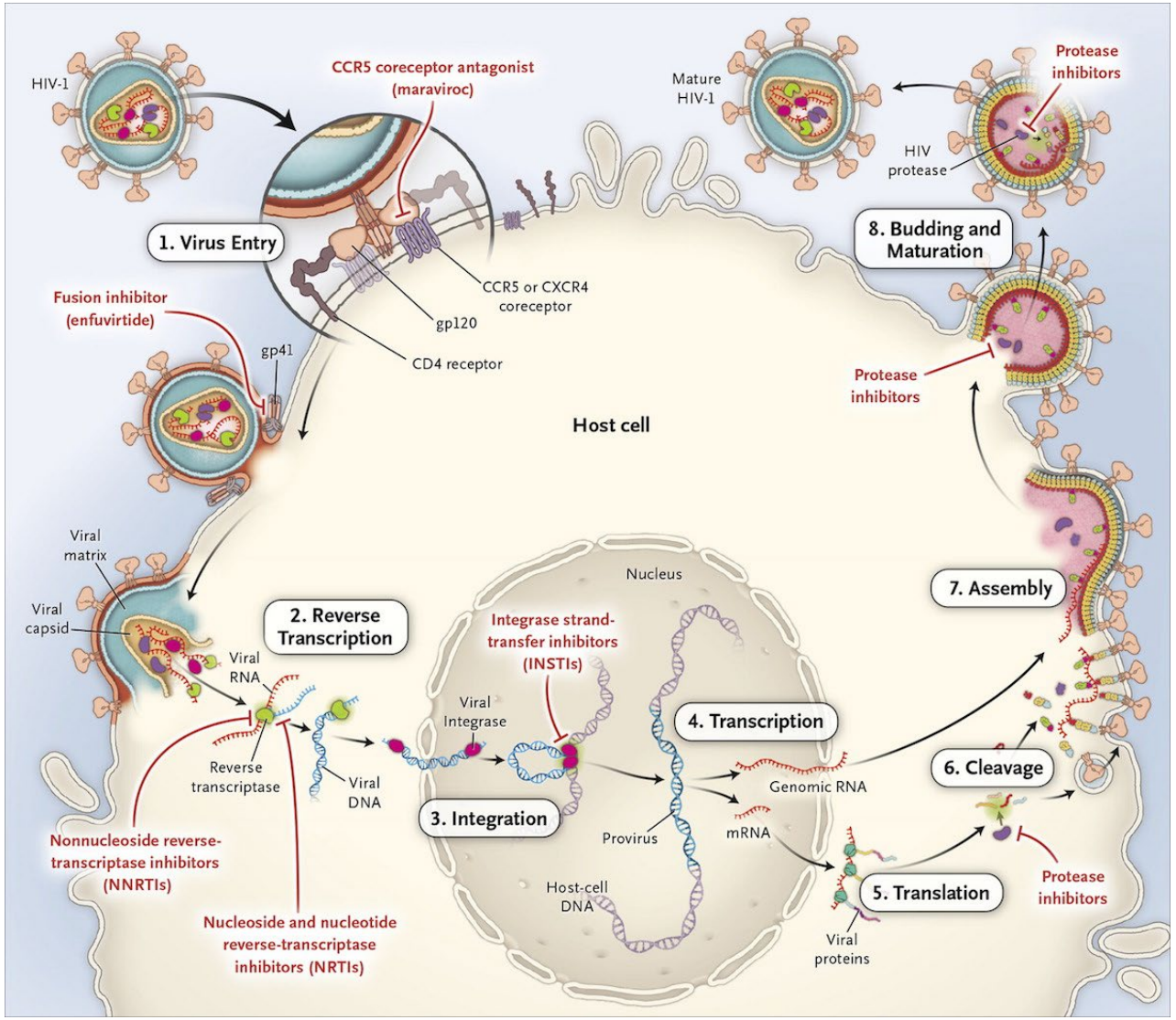
start as soon as possible

Elite controller:

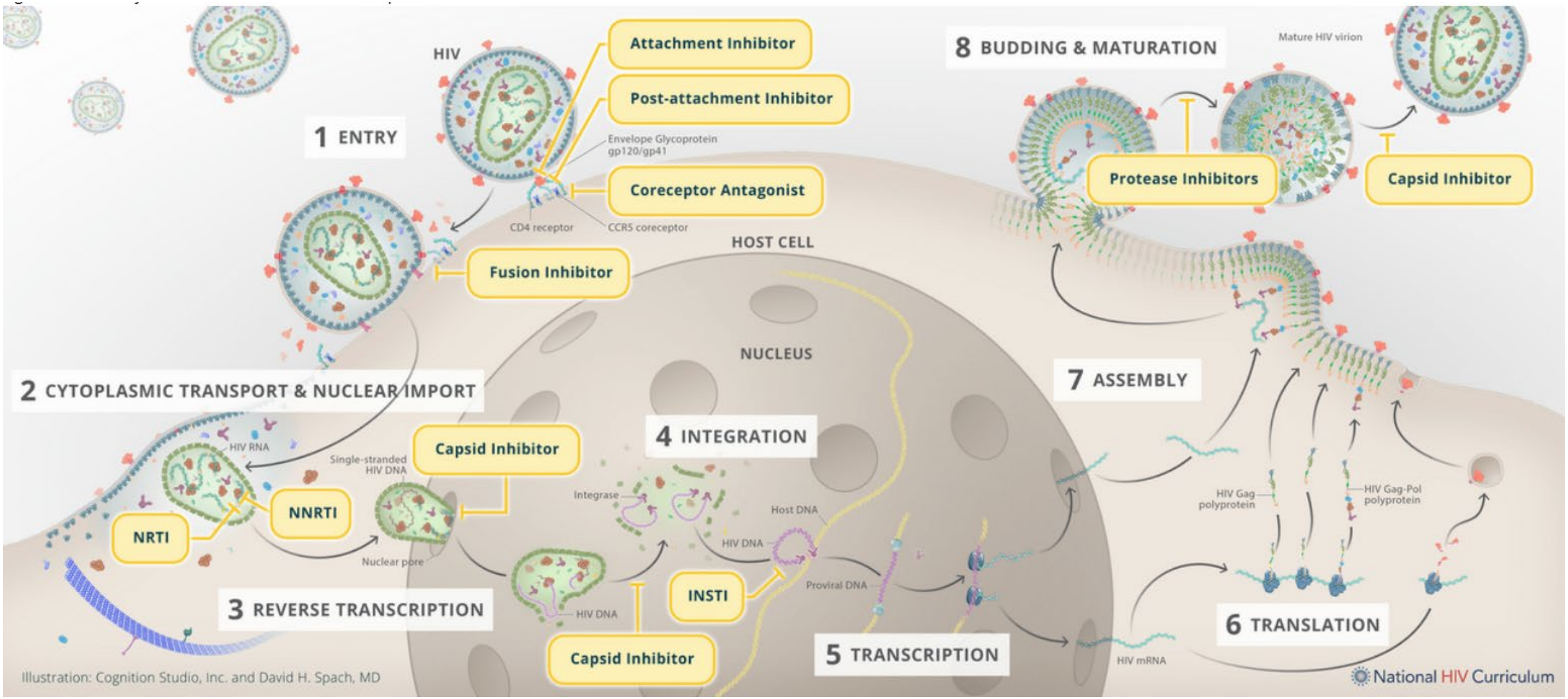
generally, recommend starting

TYPES OF ART?

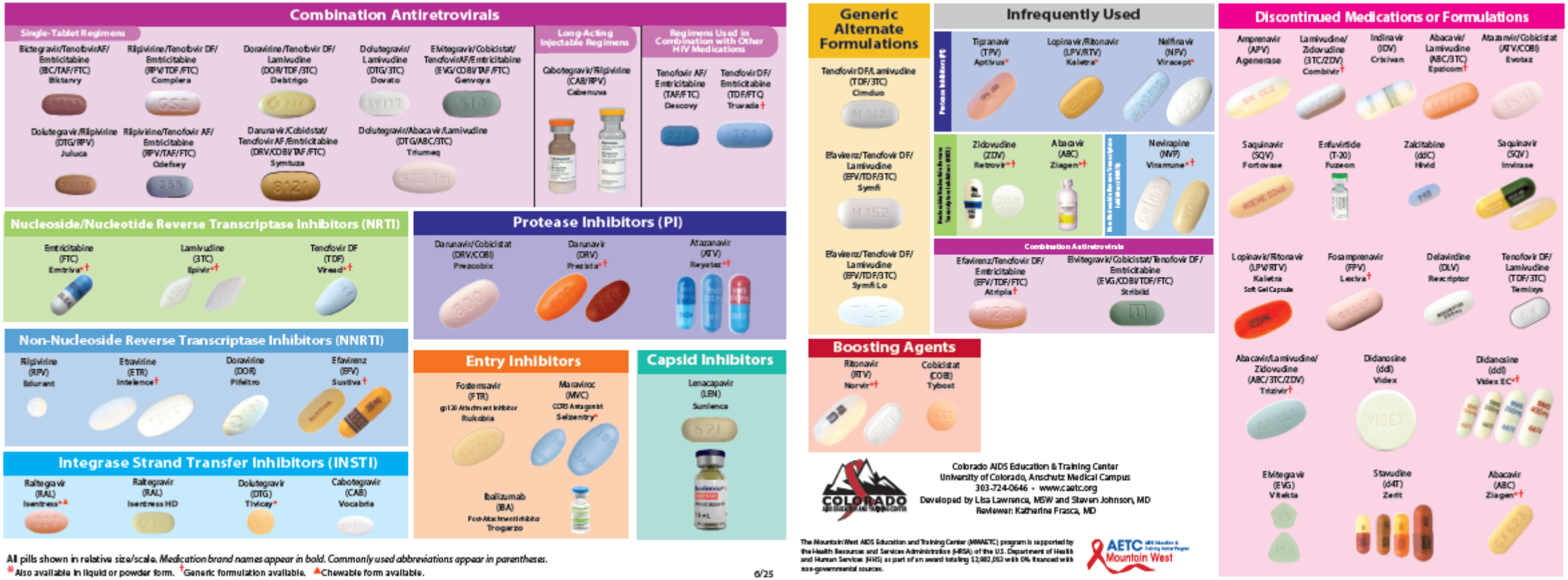
- Nucleoside/Nucleotide Reverse Transcriptase Inhibitors (NRTI)
- Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTI)
- Integrase Inhibitors (INSTI)
- Protease Inhibitors (PI)
- Entry Inhibitors
- Capsid Inhibitors
- Post-attachment Inhibitors
- Boosting Agents



HIV LIFE CYCLE AND SITE OF INHIBITORS OF VIRAL REPLICATION



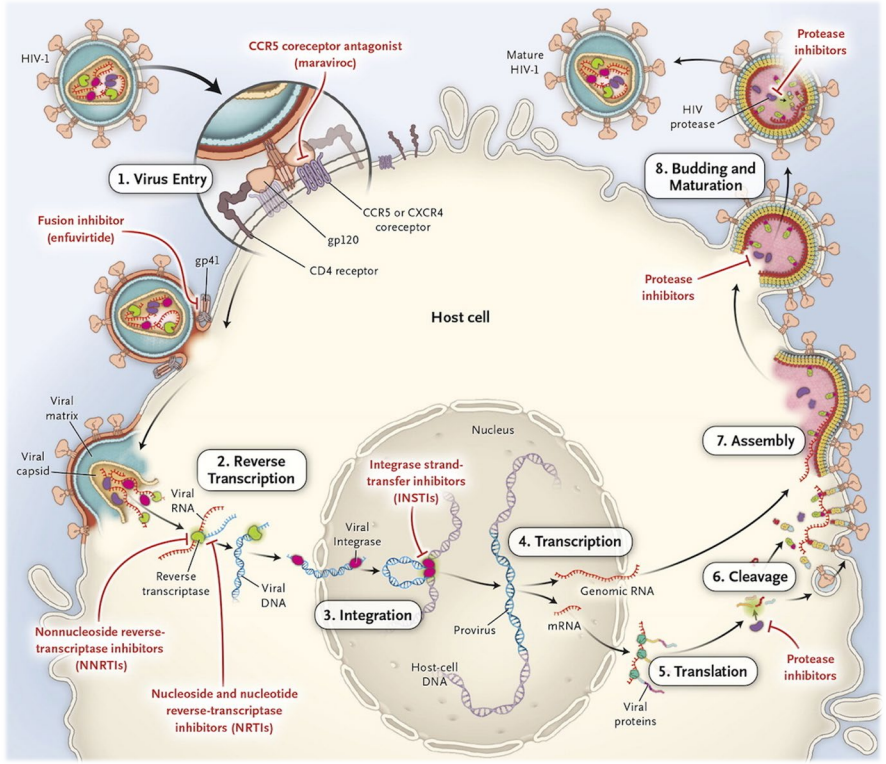
HIV MEDICATION CHART



Colorado AIDS Education & Training Center
University of Colorado, Anschutz Medical Campus
303-724-0646 • www.caetc.org
Developed by Lisa Lawrence, MSW and Steven Johnson, MD
Reviewer: Katharina Frasca, MD

The Mountain/West AIDS Education and Training Center (MWAETC) program is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $2,980,052 with 0% financed with non-governmental sources.

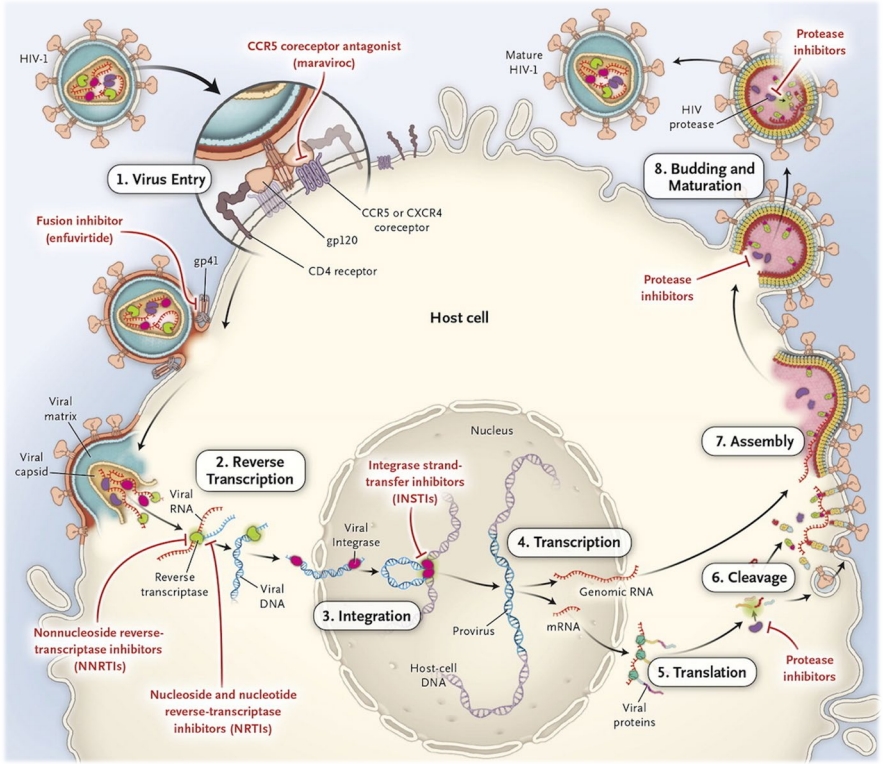
NUCLEOSIDE/NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)



- Emtriva (emtricitabine) – FTC
- Epivir (lamivudine) – 3TC
- Retrovir (zidovudine) – ZDV
- Viread (tenofovir DF) – TDF
- Vemlidy (tenofovir AF) – TAF
- Ziagen (abacavir) - ABC

Act as host nucleotide decoys and cause termination of the elongating HIV DNA chain

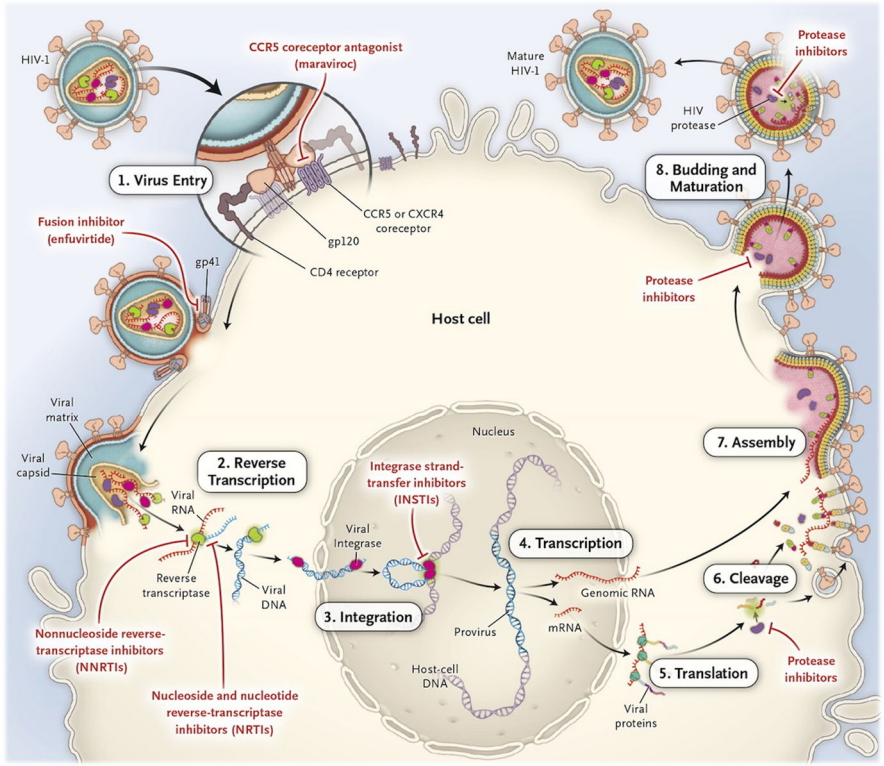
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTI)



- Edurant (rilpivirine) - RPV
- Intelence (etravirine) - ETR
- Pifeltro (doravirine) - DOR
- Sustiva (efavirenz) - EFV
- Viramune (nevirapine) - NVP

Bind directly to HIV reverse transcriptase enzyme and inhibit the function of the enzyme

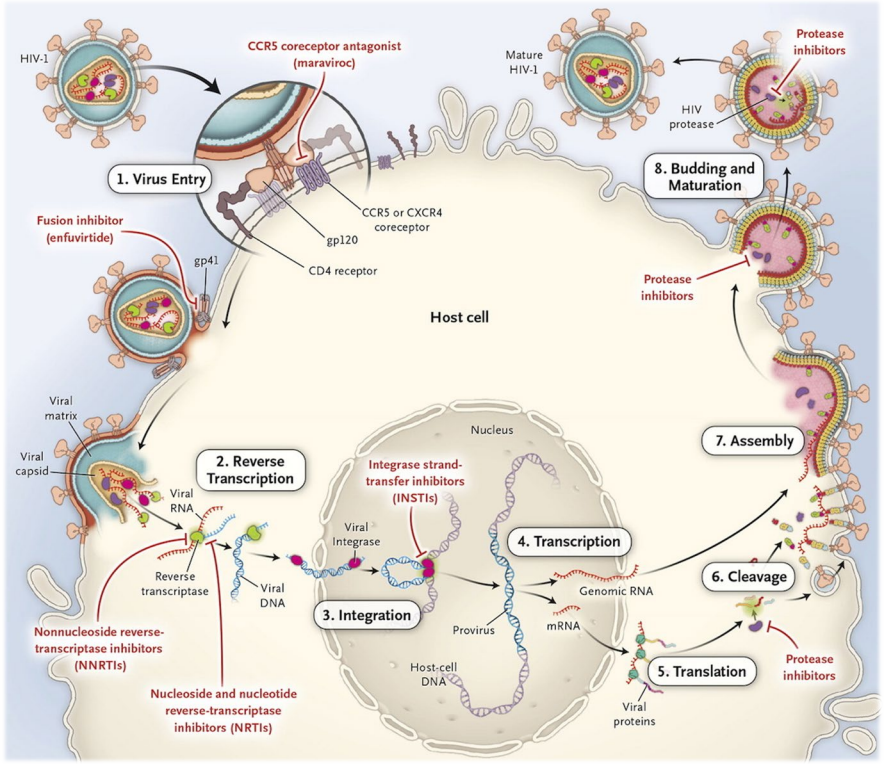
INTEGRASE INHIBITORS (INSTI)



- Isentress (raltegravir) - RAL
- Isentress HD (Raltegravir) - RAL
- Tivicay (dolutengravir) - DTG

Utilize multiple mechanisms to block the integrase enzyme

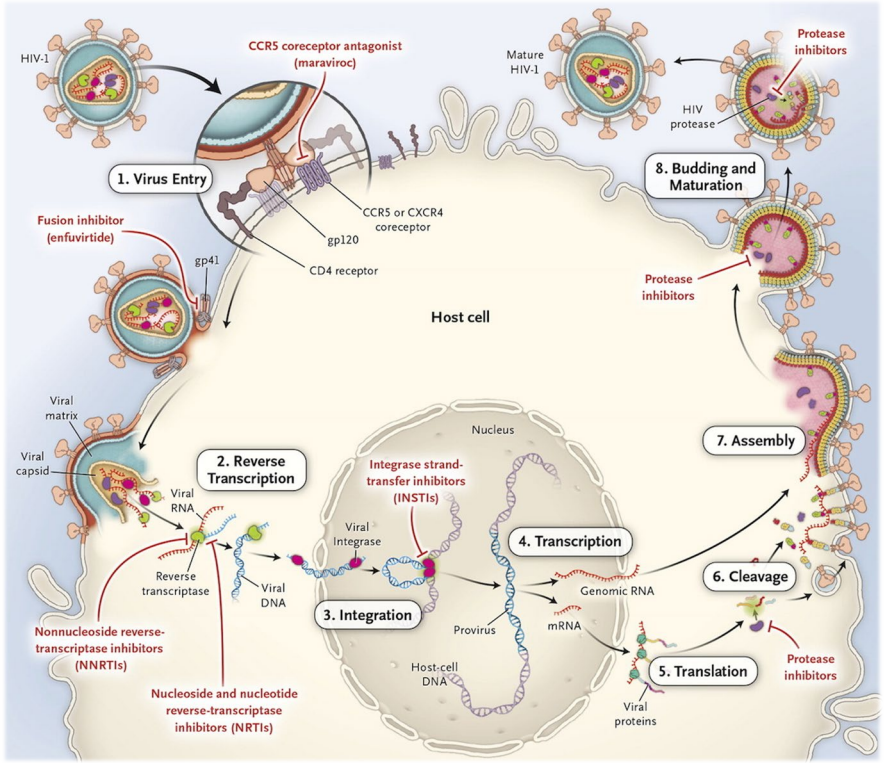
PROTEASE INHIBITORS (PI)



- Lexiva (fosamprenavir) - FPV
- Prezista (darunavir) - DRV
- Reyataz (atazanavir) - ATV
- Viracept (nelfinavir) - NFV

Bind to the active site of HIV protease and inhibit protease enzyme activity

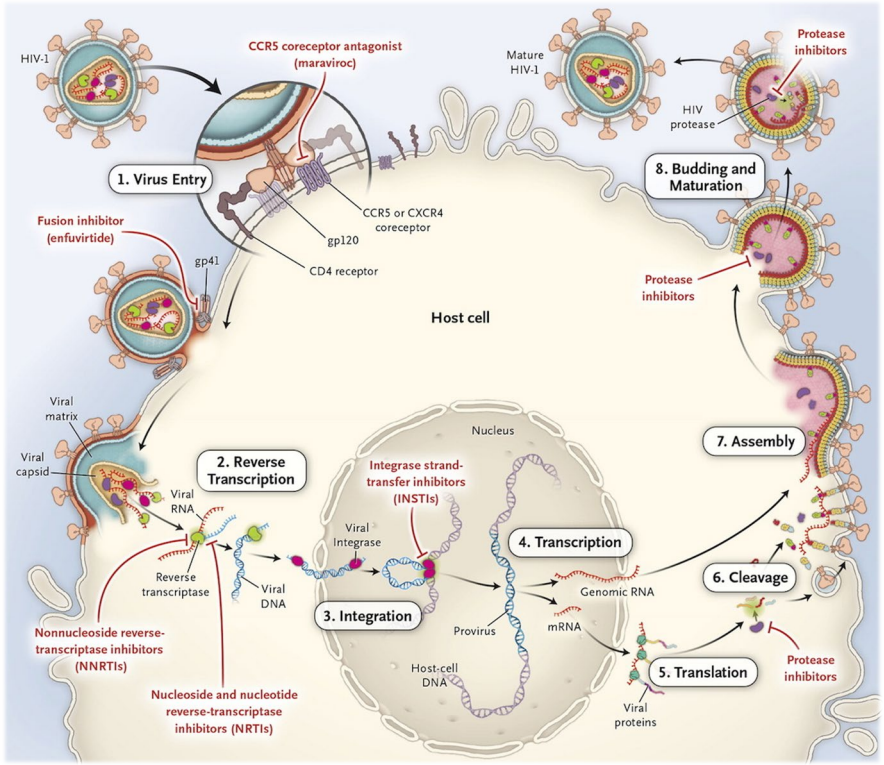
ENTRY INHIBITORS



- Fuzeon (enfuvirtide) -- T-20 – Fusion Inhibitor
- Selzentry (maraviroc) – MVC – CCR5 Antagonist
- Trozargo (ibalizumab) – IBA – Post attachment inhibitor

In short, they prevent HIV from entering the host cell (attachment, receptor biding, fusion with membrane)

BOOSTING AGENTS



- Norvir (ritonavir) - RTV
- Tybost (cobicistat) - COBI

THAT'S ALL GREAT… BUT WHAT DO I START?

Start with a "backbone" of two NRTIs

- Tenofovir-emtricitabine
- Avoid abacavir whenever possible
- Avoid Tenofovir DF if kidney disease/osteoporosis

Then add a third "anchor" drug

- Can be NNRTI, PI, or INSTI
- Bictegravir or dolutegravir

- The Panel on Antiretroviral Guidelines for Adults and Adolescents (the Panel) recommends antiretroviral therapy (ART) for all people with HIV to reduce morbidity and mortality (AI) and to prevent transmission of HIV to others (AI)
- The Panel recommends initiating ART immediately (or as soon as possible) after HIV diagnosis to increase the uptake of ART and linkage to care, decrease the time to viral suppression for individual patients, and improve the rate of virologic suppression among people with HIV (AII)
- When initiating ART, people with HIV should be counseled on the benefits, lifelong need, and importance of adherence to ART; clinicians should also identify and address barriers to care engagement and ART adherence (AIII)

RECOMMENDED INITIAL REGIMENS FOR MOST PEOPLE WITH HIV

CHOICE OF ART DURING PREGNANCY SHOULD BE GUIDED BY RECOMMENDATIONS FROM THE PERINATAL GUIDELINES

For people who do not have a history of using CAB-LA as PrEP, one of the following regimens is recommended[a]:

- BIC/TAF/FTC **(AI)**
- DTG plus (TAF or TDF)[b] plus (FTC or 3TC) **(AI)**
- DTG/3TC **(AI)**, except for individuals with HIV RNA >500,000 copies/mL, HBV coinfection, or in whom ART is to be started before the results of HIV genotypic resistance testing for reverse transcriptase or HBV testing are available.

For people who have a history of CAB-LA use as PrEP, INSTI genotype resistance testing should be performed before starting ART. If ART is to be started before results of genotypic testing results, the following regimen is recommended:

- DRV/c[c] or DRV/r with (TAF or TDF)[b] plus (FTC or 3TC) – pending the results of the genotype test **(AIII)**

Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents With HIV

ANTIRETROVIRAL REGIMEN CONSIDERATIONS

FOR INITIAL THERAPY BASED ON SPECIFIC CLINICAL SCENARIOS

Patient or Regimen Characteristics	Clinical Scenario	Consideration(s)	Rationale/Comments
ART-Specific Characteristics	A one-pill, once daily regimen is desired	**STR Options as Initial ART Include the Following:** ▪ BIC/TAF/FTC ▪ DOR/TDF/3TC ▪ DRV/c/TAF/FTC ▪ DTG/ABC/3TC ▪ DTG/3TC ▪ RPV/TAF/FTC	**Do not use** DTG/ABC/3TC if the patient is HLA-B*5701 positive DTG/3TC **is not recommended** if HIV RNA is >500,000 copies/mL **Do not use** DTG/ABC/3TC or DTG/3TC in the setting of HBV coinfection without another HBV agent **Do not use** RPV/TAF/FTC if HIV RNA is >100,000 copies/mL and CD4 count is <200 cells/mm^3

Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents With HIV

ANTIRETROVIRAL REGIMEN CONSIDERATIONS
FOR INITIAL THERAPY BASED ON SPECIFIC CLINICAL SCENARIOS

Pre-ART Characteristics	CD4 count <200 cells/mm³	**Do not use** RPV-based regimens	Higher rates of virologic failure have been observed in those with low pre-treatment CD4 counts
	HIV RNA >100,000 copies/mL *(also see next row if HIV RNA >500,000 copies/mL)*	**Do not use** RPV-based regimens	Higher rates of virologic failure have been observed in those with high pre-treatment HIV RNA levels
	HIV RNA >500,000 copies/mL	**Do not use** the following regimens: ▪ RPV/TAF/FTC ▪ DTG/3TC	For DTG/3TC, limited data are available in patients with viral loads above this threshold
	HLA-B*5701 positive or result unknown	**Do not use** ABC-containing regimens	ABC hypersensitivity is a potentially fatal reaction that is highly associated with the HLA B*5701 allele
	Prior exposure to oral TDF/(3TC or FTC) or TAF/3TC PrEP	Use DTG or BIC plus two NRTIs DTG/3TC could be considered if testing confirms no 3TC resistance mutations	DTG/3TC should be avoided if resistance testing results are not available, as presence of 3TC resistance mutations may lead to use of DTG monotherapy
	Prior exposure to CAB-LA for PrEP	INSTI genotype resistance testing should be performed **If INSTI Resistance is Present or if ART Needs to be Started Before Genotype Test Results** ▪ (DRV/r or DRV/c) plus (TAF or TDF)[a] plus (3TC or FTC) **If No INSTI Resistance is Identified** ▪ BIC/TAF/FTC, *or* ▪ DTG plus (TAF or TDF)[a] plus (3TC or FTC)	Mutations conferring resistance to INSTIs have been seen in association with CAB-LA PrEP CAB-LA has a very long half-life, and drug exposure may persist at levels suboptimal to prevent infection and may select for INSTI-resistant virus
	People with no prior exposure to CAB-LA for PrEP and ARV regimen should be started rapidly and before HIV drug resistance results are available	Avoid ABC, DTG/3TC, and NNRTI-based regimens Use ▪ BIC/TAF/FTC, *or* ▪ DTG plus (TAF or TDF)[a] plus (3TC or FTC) In People Who Used INSTI-Based ART for PEP or Who are Suspected to Have Acquired HIV from Someone Failing an INSTI-Based Regimen ▪ Obtain INSTI genotypic resistance test and start one of the following regimens: BIC/TAF/FTC, *or* DTG plus (TAF or TDF)[a] plus (3TC or FTC)	Transmitted mutations conferring NNRTI and NRTI resistance are more likely than mutations associated with PI or INSTI resistance HLA-B*5701 results may not be available rapidly; thus, ABC is not recommended Because of the current low rates of transmitted INSTI resistance in the United States, even when there is suspicion that HIV was acquired from a partner with virologic failure while on an INSTI, an INSTI-based regimen can be started, pending the results of the INSTI genotype

WHEN TO DELAY START OF ART IN PRIMARY CARE

RATHER THAN DELAY – MAKE URGENT REFERRAL TO INFECTIOUS DISEASE

- RARE TO DELAY
- PATIENT PREFERENCE
- MULTIPLE SEVERE, POORLY MANAGED CO-MORBIDITIES
- PRIOR HISTORY OF MULTIPLE ART REGIMENS
- FOR SOME SEVERE OPPORTUNISTIC INFECTIONS

What NOT to do!

- Monotherapy with ANY ARV Regimen
- Dual therapy with two NRTIs
- Triple therapy with three NRTIs
- TAF plus TDF

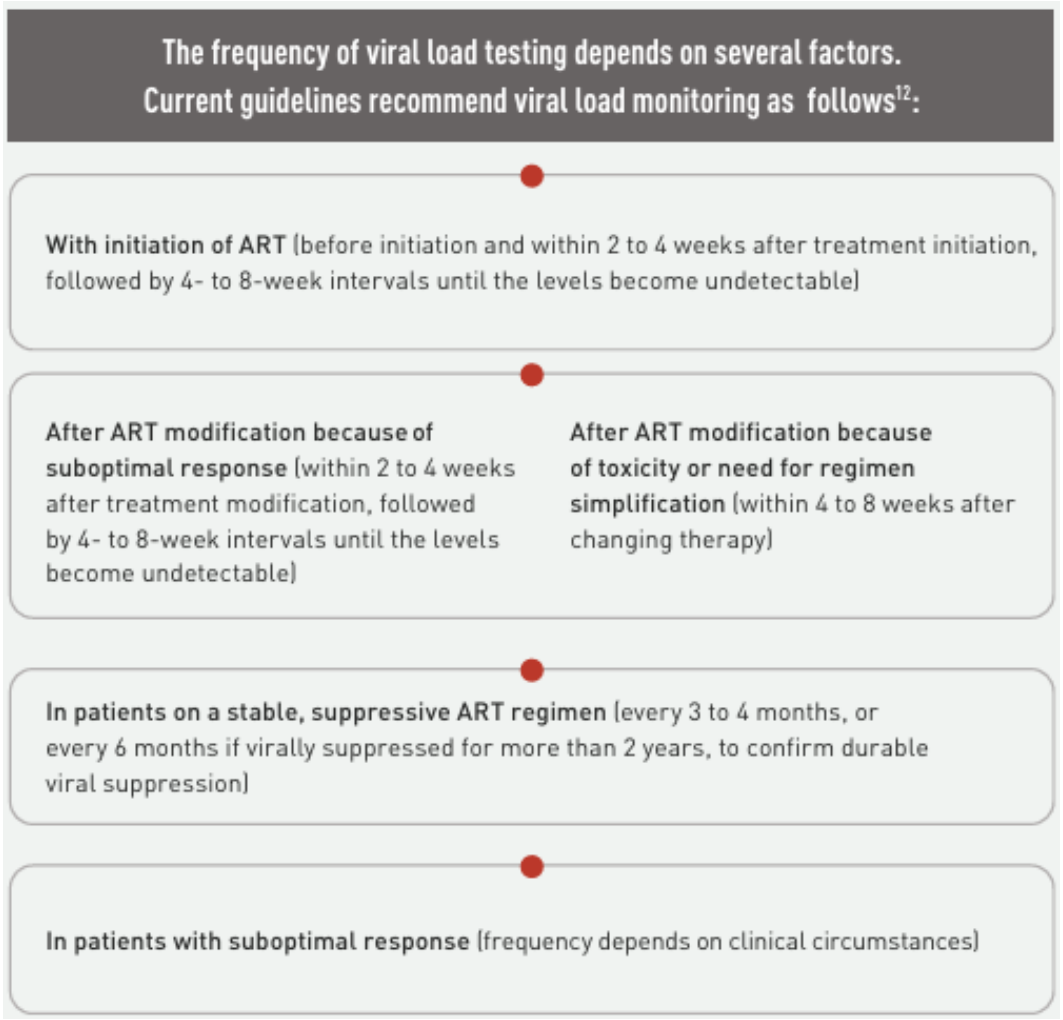
MEDICATIONS TO AVOID

Medications	Comments	Rating
▪ ABC ▪ RPV ▪ EFV ▪ DTG/3TC	▪ ABC should be avoided unless a patient is confirmed to be HLA-B*5701 negative ▪ RPV should be administered ***only*** in patients confirmed to have a CD4 cell count ≥200 cells/mm3 and a viral load <100,000 copies/mL ▪ EFV is not as well tolerated as other antiretroviral medications, and NNRTIs have higher rates of resistance ▪ DTG/3TC requires baseline resistance testing and is not recommended when HBV status is unknown	A3

MONITORING RESPONSE TO MEDICATIONS

- Baseline HIV viral load and CD4
- **ANY time there is a change in clinical status – recheck labs**
- Recheck a CD4 every 3-6 months for the first 2 years of therapy – Then:
  - If less than 300 – every 3-6 months
  - 300-500 – every 12 months
  - If consistently greater than 500 – optional (Complete Health still checks every 12 months)
- Repeat viral load in 2-8 weeks, no later than 8 weeks
  - Recheck VL every 4-8 weeks until virally suppressed
  - After fully suppressed – extend VL to every 3-4 months for 1-2 years
  - Long-term suppression – VL every 6 months

HOW DO I MONITOR MY PATIENTS' VIRAL LOAD



A patient's plasma HIV RNA viral load should be measured regularly to confirm initial and sustained response to ART. Most patients taking ART as prescribed achieve viral suppression within 6 months.

RECOMMENDED FREQUENCY OF CD4 MONITORING

September 2025 HHS Guidelines Update:

Clinical Scenario	CD4 Monitoring
After initiating ART	3 months after initiation
During first 1-2 years of ART with viral suppression and CD4 count ≥300 cells/mm^3	Every 6 months
After 1-2 years of ART with viral suppression and CD4 count ≥300 cells/mm^3	Optional
If CD4 count <300 cells/mm^3	Every 3-4 months
After modifying ART due to virologic failure	Every 3 to 6 months

GUIDELINES UPDATE SUMMARY

KEY MESSAGES

Emphasizes importance of considering cardiovascular and metabolic comorbidities for PWH

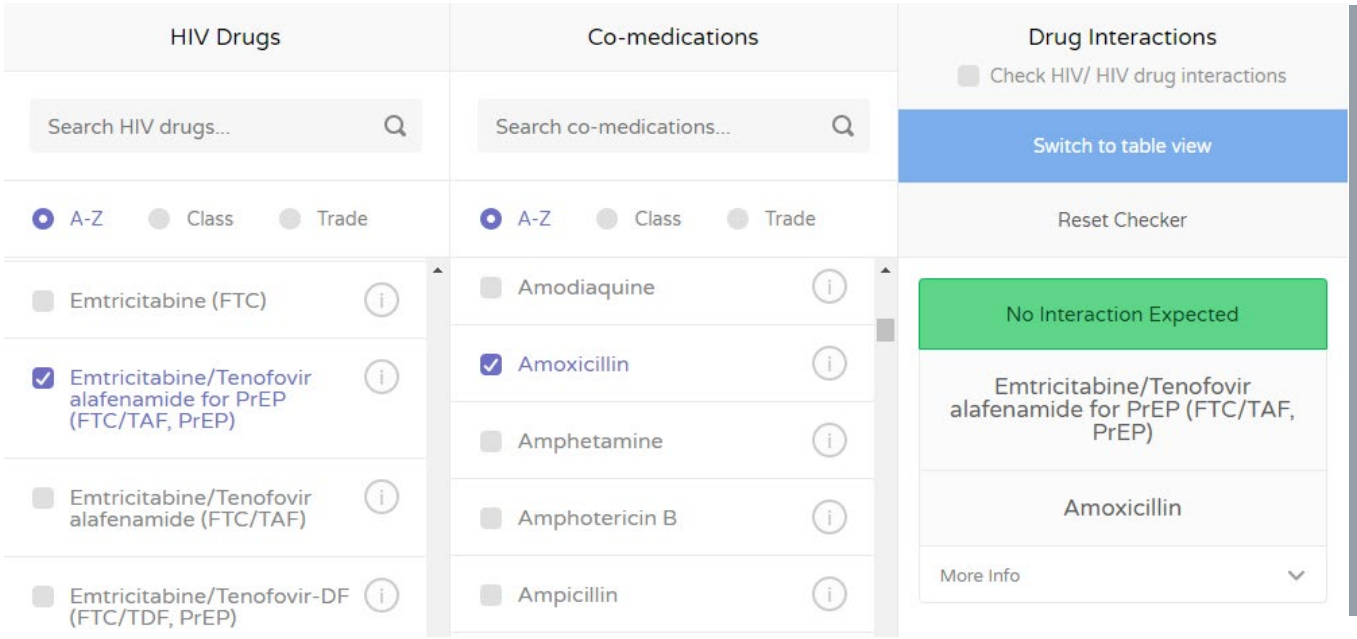
Underscores that managing comorbidities is more important than changing ART for most individuals with cardiometabolic complications

Emphasizes that CD4 count monitoring is not necessary for individuals with a suppressed viral load and good CD4 recovery

Highlights benefit of early ART, ART started during a hospitalization, and ART for elite controllers

MY PATIENT IS ON OTHER MEDS – NOW WHAT DO I DO?

HIV and HCV Drug Interactions: Quick Guides for Clinicians



HIVinfo.NIH.gov: HIV treatment – side effects

University of Liverpool: HIV Drug Interactions Checker

MEDICATIONS – KEY CONCEPTS

STEROIDS

- HIV medications can increase concentrations
  - Cushing's syndrome adrenal suppression
- More common with "boosters"
- Adjust dosing for:
  - Most inhaled steroids
  - Prednisone
- AVOID Flonase

OVER THE COUNTER (OTC) MEDS

- St. John's Wort – CP450 3A4
  - May reduce concentration of PIs and NNRTIs by as much as 82%
- Garlic – topic of debate
- PPIs and H2 receptor antagonists
- Antacids – magnesium and/or aluminum
  - Neutralizes stomach acids and may interfere with absorption of ART (*space out the dosing if necessary*)

PREPARING TO SEE PATIENTS WITH **NEW** HIV DIAGNOSIS

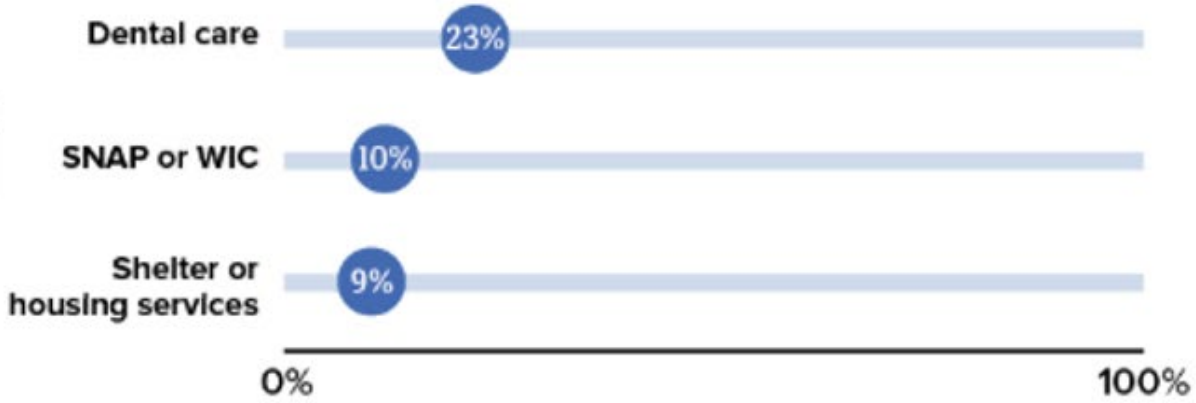
Network with community partners

- Call and establish relationship
- Advertise services – multiple avenues
- Call *ahead* of referrals
- Thank you notes
- Find your "go-to" person

KNOW YOUR COMMUNITY RESOURCES

- Local infectious disease specialists
- Local Ryan White programs
- Housing assistance
- Social work services

HAVING ACCESS TO NEEDED SERVICES COULD REDUCE BARRIERS TO ACHIEVING AND SUSTAINING VIRAL SUPPRESSION



Top 3 services women reported needing but not receiving in the past 12 months.

41% of all people with HIV needed but did not receive at least 1 HIV ancillary service in the past 12 months.

HOW CAN I SUPPORT MY PATIENTS IN STAYING ON ART?

Patient input and experience:

- Current health and social status
- Medical history and previous healthcare experience
- Short- and long-term health and treatment goals
- Knowledge of medical conditions, treatment options, and prior treatment experience
- Values and preferences
- Limitations and barriers to healthcare and engagement in care
- Available financial resources and social support

Clinician input and experience:

- Indications for screening, testing, prevention, treatment, and follow-up
- Disease natural history, epidemiology, and prognosis; risks and benefits of initiating, deferring, or declining treatment
- Recommended and alternative treatment and care options and their benefits, limitations, and risks
- Available resources for support and assistance
- Strategies for implementing various care and treatment options

Open and respectful dialogue, clinician awareness, informed and collaborative evaluation of options

Shared decision-making

Here are some examples of questions you can ask your patients to assess their ongoing adherence to ART:

- **How has it been going** taking your HIV medicines?
- What seems to **get in the way** of taking your medicines?
- **Have you missed any doses** of your medication, and if so, what was going on at that time?

Here are some suggestions to help you start the conversation with your patients:

- I know it can be difficult to keep all your appointments, but it's very important. **What can we do** to make sure you keep your next appointment?
- People with HIV do better overall when they come to their appointments on a regular basis. **How can we work together** to help you stay as healthy as possible?
- It's been a while since you last came in. **Let's talk** about what has been keeping you from coming to see me.

KEEPING PLWH ENGAGED IN CARE

…WHAT WORKED AT COMPLETE HEALTH

- In-person appointment for all new diagnoses within 7 days of test – *usually within 48 hours*
- Frequent appointment reminders
- Texting phone – provide one main contact with easy access
- Frequent follow-up appointments
- Coordination with local Ryan White Team
- On-site HIV certified pharmacist
- Availability of telemedicine for Infectious Disease Consults

FLEXIBILITY - FLEXIBILITY - FLEXIBILITY

WAYS TO HELP YOUR PATIENTS STAY IN HIV CARE,

- Improve their medication adherence,
- Achieve viral suppression,
- And improve their health outcomes

Clinic-wide marketing (such as posters and brochures) and support (such as customer service training for patient-facing staff) to promote attending scheduled visits and provide your patients with a welcoming and courteous experience.[16,17]

A patient navigator to focus on retention, adherence, and re-engagement efforts. The patient navigator can help with appointments, referrals, system navigation, service coordination, and transportation.[17]

"Data to Care" approaches that use clinic and public health data to identify patients in need of retention, re-engagement, or adherence support services to improve their health outcomes, including achieving viral suppression.[18-20]

Medication adherence support for patients in care. Encourage your patients to download apps that help with appointment and medication reminders.

Retention and re-engagement support for out-of-care persons or patients at risk of falling out of care (such as patients who missed a care visit or are experiencing barriers to care engagement).

Local or state health departments or local community-based organizations can help providers and HIV medical clinics by integrating their existing prevention services within the HIV care clinic to provide the support services your patients need to improve engagement in and adherence to HIV care.

HIV TREATMENT AND CARE TAKEAWAYS FOR PROVIDERS

1

Support your patients with HIV by monitoring and discussing their needs and linking them to services. Staying in care can be challenging, even for the most motivated patients, and their needs may change over time.

2

Emphasize the benefits of consistent, long-term adherence to medication. Positive reinforcement from health care providers can help patients maintain high levels of adherence to care appointments and HIV treatment.

3

Ask your patients open-ended questions to assess adherence to medication. Engaging patients in brief conversations at every office visit can help you build trust with your patients by becoming more familiar with each of your patients, including any challenges with adherence to their medication and barriers they face to staying in care.

LEARNING GROUP

National HIV Curriculum

www.hiv.uw.edu

Six modules with 35 lessons and corresponding Question Bank topics address:

- SCREENING AND DIAGNOSIS
- BASIC HIV PRIMARY CARE
- ANTIRETROVIRAL THERAPY
- CO-OCCURRING CONDITIONS
- PREVENTION OF HIV
- KEY POPULATIONS

CREATE FREE ONLINE LEARNING GROUPS TO:

- Invite, train, and onboard staff and residents by assigning select content
- Review group progress reports to track CE and shape future training
- Augment medical, nursing, pharmacy, dental and other healthcare professionals training programs

The Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS) provided financial support for the National HIV Curriculum. The award provided 100% of total costs and totaled $1,172,994. The contents are those of the author. They may not reflect the policies of HRSA, HHS, or the U.S. Government.

www.hiv.uw.edu

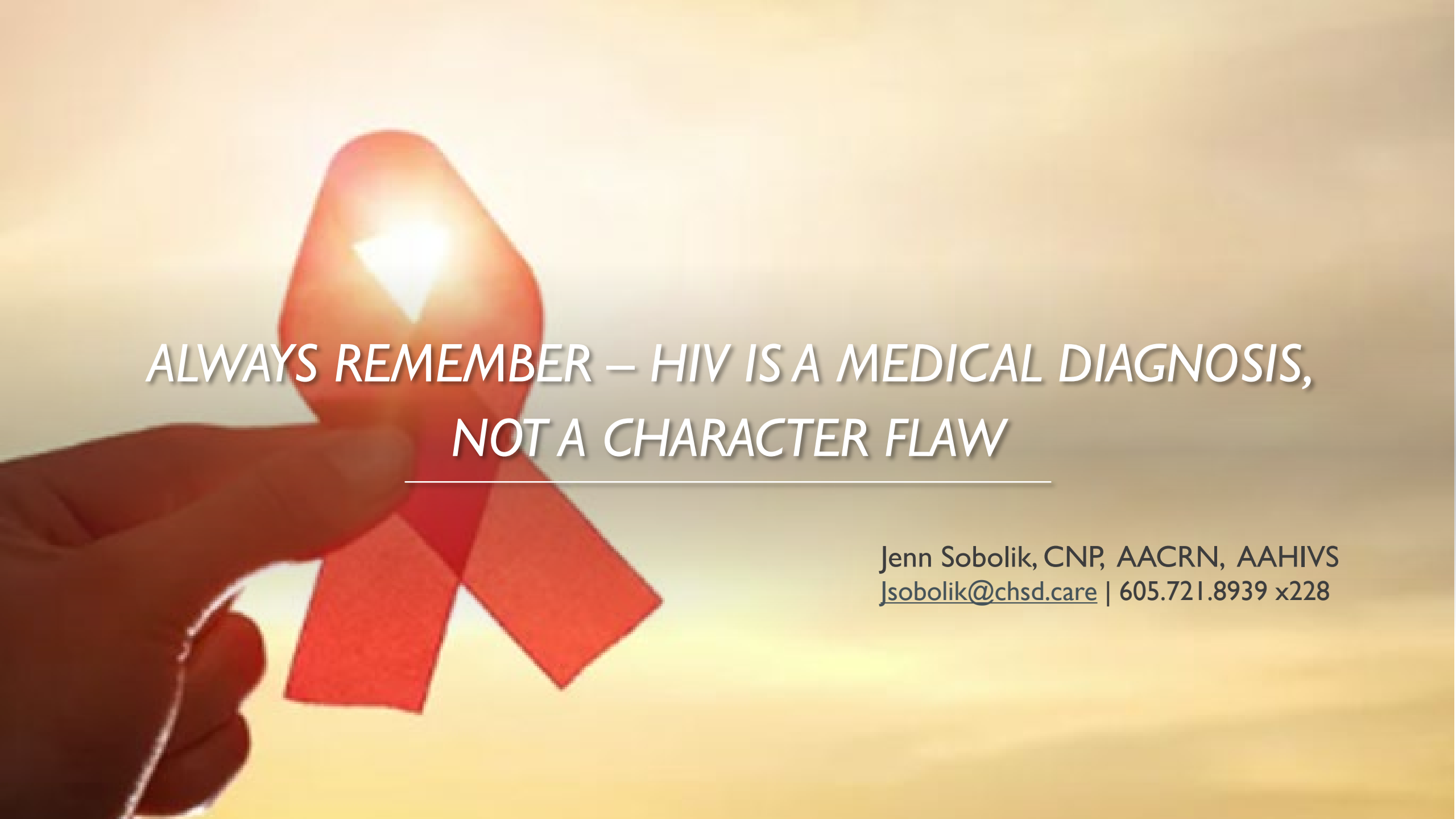
Free, up-to-date website for healthcare professionals to learn about HIV diagnosis, treatment, and prevention

FREE CME, CNE, APN PHARMACOLOGY CE, CE, AND CERTIFICATES OF COMPLETION

VISIT THE SITE TO:

- Access **35 Self Study lessons**, earn free CE and CoC, and track progress
- Search for current information or scan through the **Quick Reference** section
- Answer 380+ board-review style questions in the **Question Bank** and earn free CE
- Use 17 clinical screening **Tools & Calculators** to help with clinical decisions
- Explore **Antiretroviral Medications**, review clinical trials, and view slide decks
- Listen to **Podcast** episodes exploring practice-changing issues and updates
- Watch clinically relevant, concise **Mini-Lectures** to supplement learning
- Examine **5 HIV Symptom Evaluation Guides** about common symptoms

University of Washington (UW) Professor of Medicine Dr. David Spach is Editor-in-Chief of this site and four other curricula about HIV PrEP, STDs, HCV, and HBV. All sites offer FREE CE. Created and managed by the UW Infectious Diseases Education & Assessment (IDEA) Program (idea.medicine.uw.edu).



ALWAYS REMEMBER – HIV IS A MEDICAL DIAGNOSIS, NOT A CHARACTER FLAW

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