

ROUTINE HIV MANAGEMENT | LOW BARRIER CARE



CARING WITH CONFIDENCE

Integrating HIV Testing, Management, and Prevention in Primary Care

March 25, 2026

Key Concepts:

- Integrating HIV care into routine primary care visits
- Laboratory workup for individuals living with HIV
- Overview of HIV medications and prescribing basics
- Common HIV-related symptoms and differentiating non-HIV related issues



JENNIFER SOBOLIK, CNP, AACRN, AAHIVS, CARN-AP

Jenn Sobolik, CNP, provides comprehensive sexual health, HIV, and substance use care at Complete Health in Rapid City. She is committed to respectful, patient-centered care in a welcoming, supportive environment. Her clinical focus includes STI testing and treatment, family planning, HIV testing and prevention, PrEP/PEP, and primary care for people living with HIV.

No financial interests to disclose



FUNDING ACKNOWLEDGEMENT

This Mountain West AIDS Education and Training (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 \$2,820,772 with 0% financed with non-governmental sources.

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OBJECTIVES

- Discuss the HIV Care Continuum
- Understand basic person-first language related to HIV
- Review basic HIV monitoring after a new diagnosis
- Overview of health maintenance and chronic condition management in PLWH
 - Diabetes, Hypertension, Hyperlipidemia, Substance Use
- Review immunization schedules for PLWH
- Cancer Screenings for PLWH



HIV CARE CONTINUUM:

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

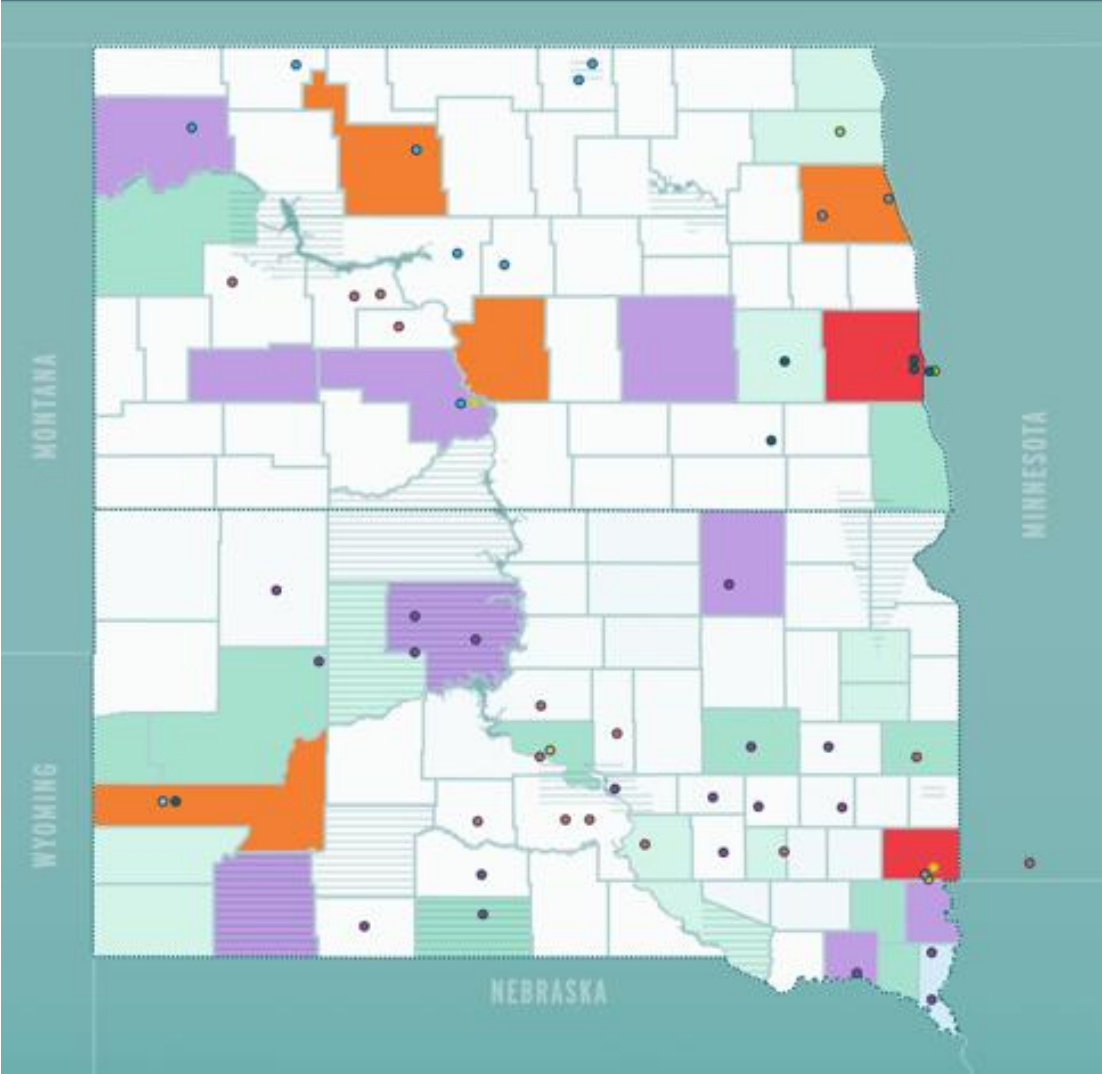
POLLING QUESTION

On a scale of 1 to 5, my comfort level with antiretroviral management is...

- 1) I have never prescribed antiretrovirals for either HIV prevention or HIV treatment
- 2) I've given nirmatrelvir/ritonavir (Paxlovid®), does that count?
- 3) I have some patients on HIV pre-exposure prophylaxis (PrEP)
- 4) I have prescribed PrEP, and have also prescribed antiretroviral treatment with support from an HIV expert/ID specialist
- 5) I am very comfortable managing



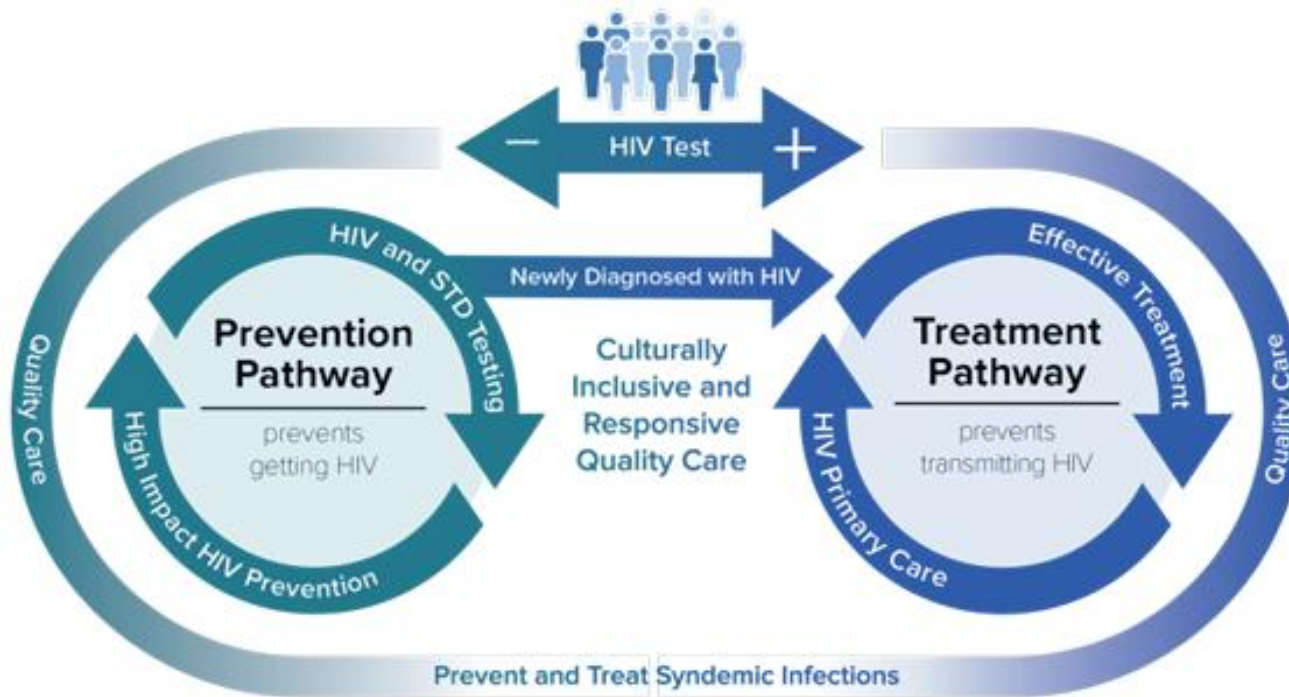
LIVING WITH HIV/AIDS CASES IN ND/SD BY COUNTY



NORTH DAKOTA SOUTH DAKOTA



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.

Stigmatizing Terms To Avoid	Use These Alternatives	Here's Why
<p>HIV infection/HIV-infected</p> <p><i>Related terms to avoid: HIV-infected people, HIV positives, HIV carriers, people infected with HIV, HIV-uninfected people</i></p>	<ul style="list-style-type: none"> ✓ HIV ✓ People/person living with HIV ✓ People/person with HIV ✓ HIV status ✓ HIV diagnoses ✓ HIV acquisition ✓ HIV transmission 	<p>"Infection" carries the stigma of being contagious, a threat, or unclean. HIV advocates frequently highlight the damaging consequences of this word choice. In specific situations, the term "HIV infection" is necessary to describe the biological process. In most cases, however, "HIV" alone accomplishes the necessary communication.</p> <p>Person-first language emphasizes humanity. "Living with" is an affirmation of life many advocates prefer. "Poz" is also sometimes used by community members themselves.</p>

Stigmatizing Terms To Avoid	Use These Alternatives
HIV-infected, HIV-infection*, HIV-positive [people, individuals, populations]	People living with HIV, people with HIV (*see page 8 for comments on use of "HIV-infection")
Subject	Participant, volunteer
Sterilizing cure	HIV eradication, HIV clearance
AIDS (when referring to the virus, HIV)	HIV, HIV and AIDS when referring to both
Mother-to-child transmission	Perinatal transmission
Verticals	Lifetime survivors
At-risk or high-risk person/population	Person/population with greater likelihood of ..., high incidence population, affected community
Target population	Key population/engage or prioritize a population
Hard-to-reach population	Under-resourced, underserved by [specific resource/service], population(s) experiencing discrimination/racism/transphobia

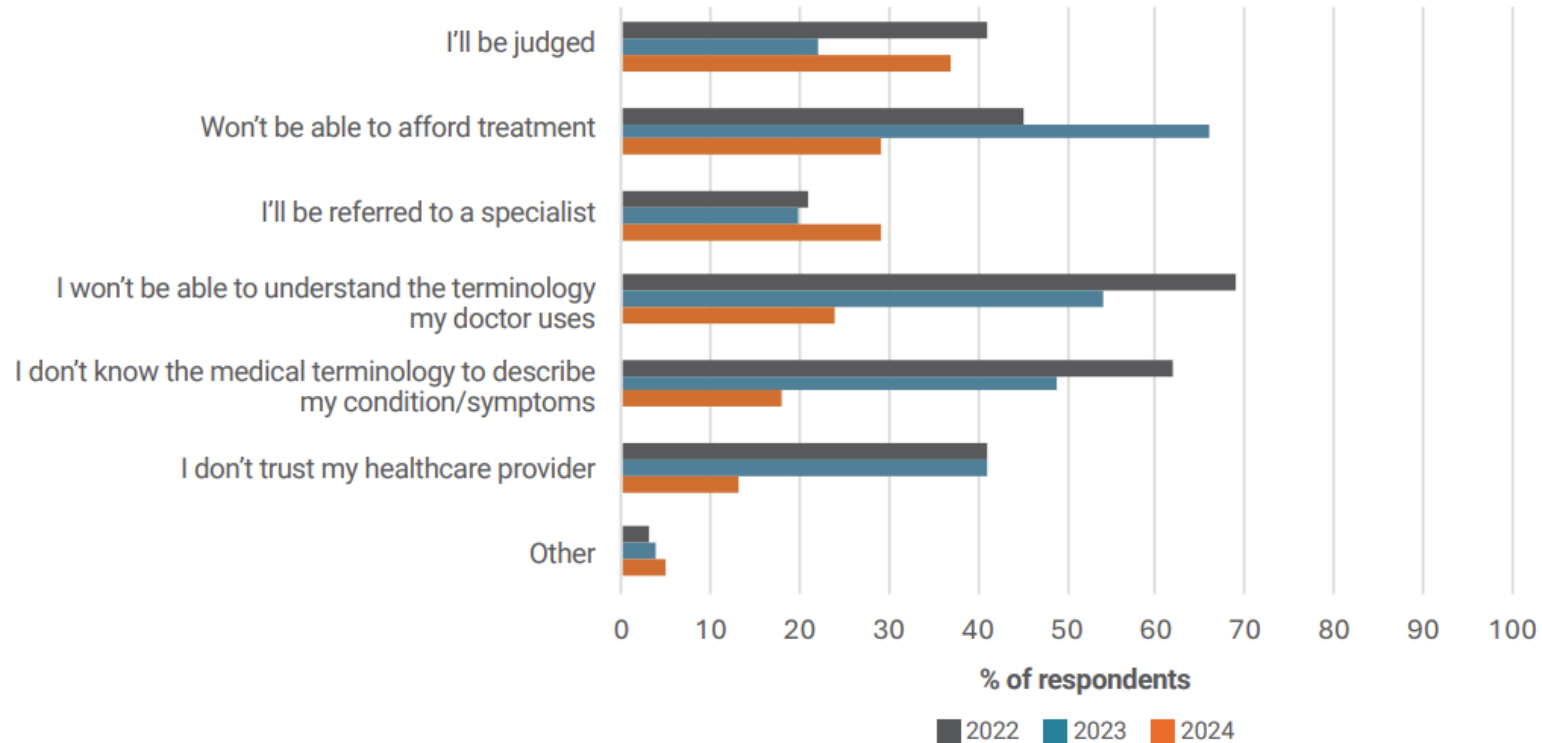


Person-first language is a way to emphasize the person and view the disorder, disease, condition, or disability as only one part of the whole person. Describe what the person “has” rather than what the person “is.” Person-first language avoids using labels or adjectives to define someone.

[National Institute of Health \(NIH\) Style Guide HIV Language Guide](#)

PATIENT CONFIDENCE INDEX: MORE WILLING TO TALK TO THEIR PROVIDER

Why are you afraid to ask your healthcare provider about your health conditions/symptoms?



U=U
UNDETECTABLE
EQUALS
UNTRANSMITTABLE

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.

WHY DID WE SHIFT TO A “TEST AND TREAT” STRATEGY?

- Increases treatment uptake by starting ART earlier rather than delaying therapy
- Decreases time to virologic suppression by removing barriers to care
- Promotes proactive care planning, allowing care teams to address potential challenges early instead of reacting later

Median Days	2013	2014	2015	2016	2017	2018
Diagnosis to 1 st care visit	8	7	7	5	4	2
1 st care visit to ART start	27	17	7	1	0	0
ART start to VL <200 c/mL	76	54	53	42	46	35
Diagnosis to VL <200 c/mL	134	92	79	65	65	46

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*57:01
- 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 not recommended 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

ANTIRETROVIRAL THERAPY

Treatment is prevention

Earlier viral suppression

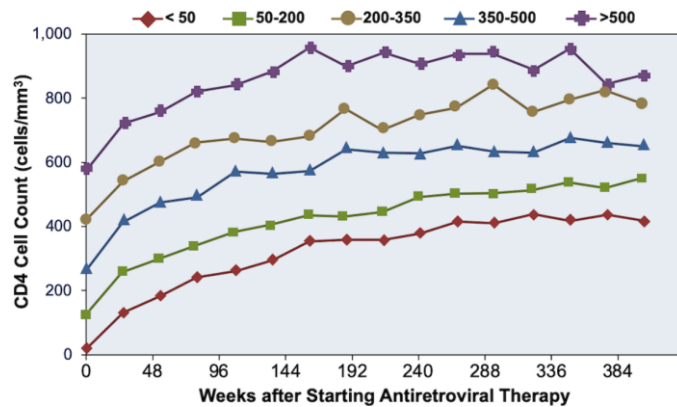
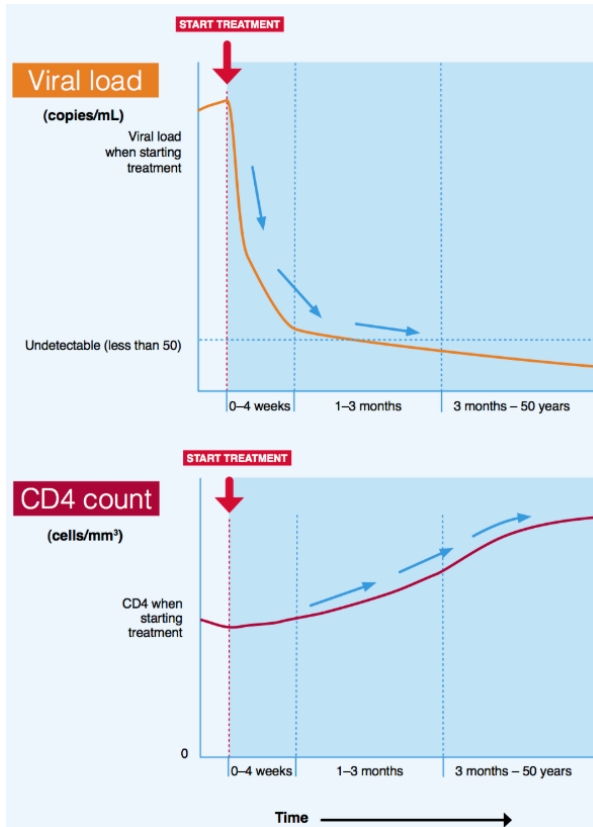
Low barrier, open access model of care

Improves linkage and retention in care

Supports early and ongoing adherence

Now considered a Standard of Care

CONTINUED EVALUATION OF HIV AFTER DIAGNOSIS

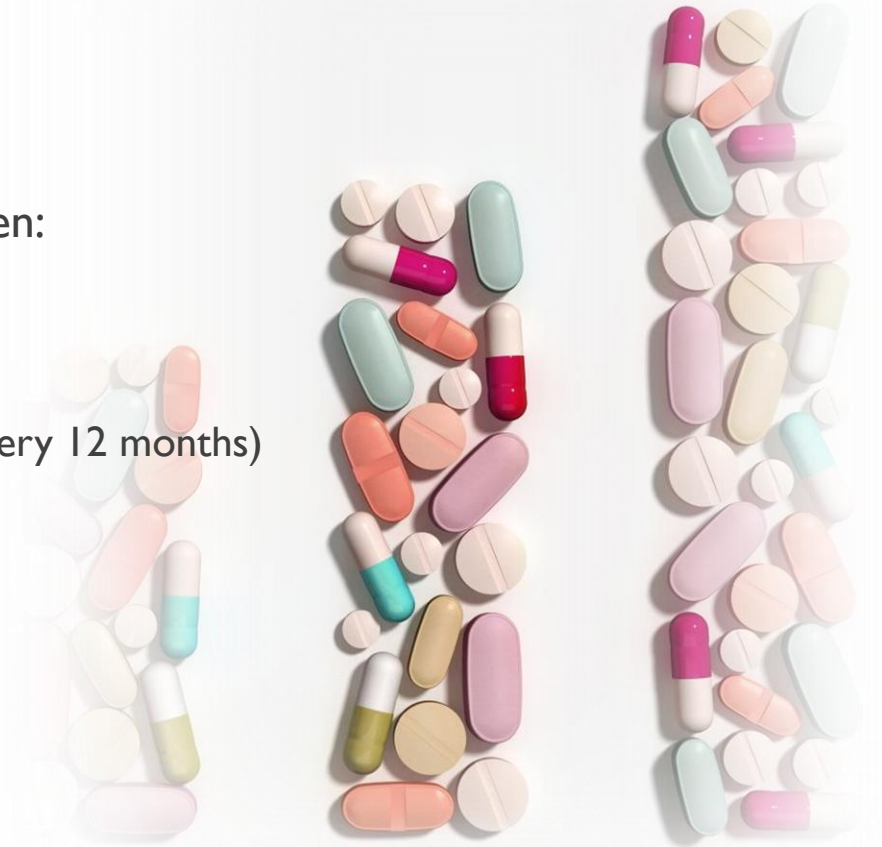


- CD4 and Viral load at diagnosis
- Then 2-4 weeks after initiating treatment
- Then approximately every 3 months for at least a year
- If stable, go to every 6 months
- Eventually, yearly if stable

❖ *Ryan White Program requires labs every 6 months*

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



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

HIV and HCV Drug Interactions: Quick Guides for Clinicians

HIV Drugs	Co-medications	Drug Interactions
<input type="text" value="Search HIV drugs..."/>	<input type="text" value="Search co-medications..."/>	<input type="checkbox"/> Check HIV/ HIV drug interactions
<input type="radio"/> A-Z <input type="radio"/> Class <input type="radio"/> Trade	<input type="radio"/> A-Z <input type="radio"/> Class <input type="radio"/> Trade	<input type="button" value="Switch to table view"/>
<input type="button" value="Reset Checker"/>		
<input type="checkbox"/> Emtricitabine (FTC)	<input type="checkbox"/> Amodiaquine	No Interaction Expected
<input checked="" type="checkbox"/> Emtricitabine/Tenofovir alafenamide for PrEP (FTC/TAF, PrEP)	<input checked="" type="checkbox"/> Amoxicillin	Emtricitabine/Tenofovir alafenamide for PrEP (FTC/TAF, PrEP)
<input type="checkbox"/> Emtricitabine/Tenofovir alafenamide (FTC/TAF)	<input type="checkbox"/> Amphetamine	Amoxicillin
<input type="checkbox"/> Emtricitabine/Tenofovir-DF (FTC/TDF, PrEP)	<input type="checkbox"/> Amphotericin B	<input type="button" value="More Info"/>
	<input type="checkbox"/> Ampicillin	



[HIVinfo.NIH.gov](https://www.hivinfo.nih.gov/): HIV treatment – side effects

[University of Liverpool: HIV Drug Interactions Checker](https://www.liverpool.ac.uk/medicine/clinical-pharmacology/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*)



HEALTH MAINTENANCE

- STI testing and Trichomoniasis at diagnosis, then every 3 months, and at least annually
- Syphilis at diagnosis, every 3 months, and at least annually
- Cervical pap at diagnosis – then routine if normal, if abnormal follow ASCCP guidelines
- Anal Pap smear – at diagnosis
- Mental Health / Substance Use Disorder Screening – bi-annually
- Cholesterol panel – at diagnosis, then 1-3 months after starting meds
- DEXA Scan – at age 50 – then based on sex characteristics at birth
- Breastfeeding – shared decision making

HEALTH MAINTENANCE

- TB Screening – At Dx and bi-annually, more if vulnerable
- Hep A/B/C Testing – At Dx and annually
 - Hep B surface Ab testing at diagnosis
- HPV vaccine – All PLWH up to age 45
- STOP SMOKING
- Dentist every 6 months
- Yearly eye exam



Source: [HIVMA/IDSA 2024 Primary Care Guidance Update for Providers Who Care for Persons with HIV](#)

2025 ACIP RECOMMENDED IMMUNIZATIONS FOR ADULTS WITH HIV, U.S.

Vaccines	Abbreviations	CD4 count <15% or <200 cells/mm ³	CD4 count ≥15% and ≥200 cells/mm ³
		Recommended Number of doses depends on vaccine and prior COVID immunization history	Recommended Number of doses depends on vaccine and prior COVID immunization history
COVID-19	1vCOV-mRNA 1vCOV-aps	Recommended Number of doses depends on vaccine and prior COVID immunization history	Recommended Number of doses depends on vaccine and prior COVID immunization history
<i>Haemophilus influenzae</i> type b	Hib	No Guidance/Not Applicable	
Hepatitis A	HepA	Recommended 2 or 3 doses depending on vaccine	
Hepatitis B	HepB	Recommended 2 or 3 doses depending on vaccine	
Human papillomavirus	9vHPV	Recommended 3 doses through age 26 years (0, 1-2, and 6 months)	
Influenza inactivated 3, or Influenza recombinant 3	IIV3 RIV3	Recommended 1 dose annually	
Influenza live, attenuated	LAIV3	Contraindicated	
Measles-mumps-rubella	MMR	Contraindicated	With no evidence of immunity Recommended 2 doses (at least 4 weeks apart)
Meningococcal serogroups A, C, W, Y	MenACWY-CRM MenACWY-TT	Recommended 2 doses (at least 8 weeks apart), then revaccinate every 5 years	
Meningococcal serogroup B	MenB-4C MenB-FHbp	No Guidance/Not Applicable	
Mpox		Recommended for Persons at Risk 2 doses (28 days apart)	
Pneumococcal	PCV15 PCV20 PCV21 PPSV23	Recommended 1 dose PCV20 or PCV21 or 1 dose PCV15 followed ≥8 weeks by 1 dose PPSV23	
Respiratory Syncytial Virus	RSV	Recommended for the Following Persons 1 dose in adults aged ≥75 years 1 dose in adults aged 60-74 years if at increased risk	
Tetanus-diphtheria-acellular pertussis Tetanus-diphtheria	Tdap Td	Recommended 1 dose Tdap then Td or Tdap booster every 10 years	
Varicella	VAR	Contraindicated	With no evidence of immunity Consider 2 doses (3 months apart)
Zoster, recombinant	RZV	Recommended 2 doses (2-6 months apart) at age ≥19 years	

¹ This table is based on the 2025 ACIP Recommended Adult Immunization Schedule by Medical Condition and Other Indications, United States.

² Recommended if CD4 count greater than 200 cells/mm³ for at least 6 months with no evidence of immunity to measles, mumps, or rubella

VACCINES IN THE ADULT IMMUNIZATION SCHEDULE

Vaccines	Abbreviations	Trade Names
COVID-19	1vCoVmRNA	Pfizer-BioNTech (<i>Comirnaty</i>) Moderna (<i>Spikevax</i>)
	1vCoVdPS	Novavax
<i>Haemophilus influenzae</i> type b	Hib	<i>ActHIB</i> <i>Hiberix</i> <i>PedvaxHIB</i>
Hepatitis A vaccine	HepA	<i>Havrix</i> <i>Vaqta</i>
Hepatitis A and hepatitis B vaccine	HepA-HepB	<i>Twinrix</i>
Hepatitis B vaccine	HepB	<i>Engerix-B</i> <i>Hepisav-B</i> <i>Recombivax HB</i>
Human papillomavirus vaccine	HPV	<i>Gardasil 9</i>
Influenza vaccine (inactivated, egg-based)	IIV3	Multiple
	aIIV3	<i>Fluad</i>
	HD-IIV3	<i>Fluzone High-Dose</i>
Influenza vaccine (inactivated, cell culture)	ccIIV3	<i>FluceLVax</i>
Influenza vaccine (recombinant)	RIV3	<i>Flublak</i>
Influenza vaccine (live, attenuated)	LAIV3	<i>FluMist</i>
Measles, mumps, and rubella vaccine	MMR	M-M-R II <i>Priorix</i>
Meningococcal serogroups A, C, W, Y vaccine	MenACWY-CRM	<i>Menveo</i>
	MenACWY-TT	<i>MenQuadfi</i>
Meningococcal serogroup B vaccine	MenB-4C	<i>Bexsero</i>
	MenB-FHbp	<i>Trumenba</i>
Meningococcal serogroups A, B, C, W, Y vaccine	MenACWY-TT/Men B-FHbp	<i>Penbraya</i>
Mpox vaccine	Mpox	<i>Jynneos</i>
Pneumococcal conjugate vaccine	PCV15	<i>Vaxneuvance</i>
	PCV20	<i>Prenar 20</i>
	PCV21	<i>Capvaxiv</i>
Pneumococcal 23-valent polysaccharide vaccine	PPSV23	<i>Pneumovax 23</i>
Respiratory syncytial virus vaccine	RSV	<i>Abrysvo</i> <i>Arexy</i> <i>mResvia</i>
Tetanus and diphtheria toxoid vaccine	Td	<i>Tenivac</i>
Tetanus and diphtheria toxoids and acellular pertussis vaccine	Tdap	<i>Adacel</i> <i>Boostrix</i>
Varicella vaccine	VAR	<i>Varivax</i>
Zoster vaccine, recombinant vaccine	RZV	<i>Shingrix</i>

Source: Centers for Disease Control and Prevention. Vaccines in the Adult Immunization Schedule. [\[CDC\]](#)

IMMUNIZATIONS – KEY POINTS

- NO LIVE VACCINES – avoid FluMist
- Know your CD4 before giving vaccinations
 - No varicella, MMR, or Zoster if CD4 is less than 200
- Yes, they need a Covid vaccine and a flu vaccination
- [CDC: Vaccines & Immunizations](#)



VACCINE EFFICACY WITH LOW CD4 COUNTS

- Current or advanced immunosuppression in people with HIV can lead to reduced responses to standard vaccine doses
- Vaccine response may depend on both current CD4 count and nadir (lowest recorded) CD4 count
- Higher CD4 counts are generally associated with better vaccine responses
- Immune reconstitution from antiretroviral therapy (ART) can improve vaccine effectiveness
- Vaccination is usually not delayed while waiting for CD4 counts to rise above 200 cells/mm³

Challenges with Efficacy

CANCER SCREENINGS **NOT** IMPACTED BY HIV

BREAST CANCER

COLON CANCER

LUNG CANCER

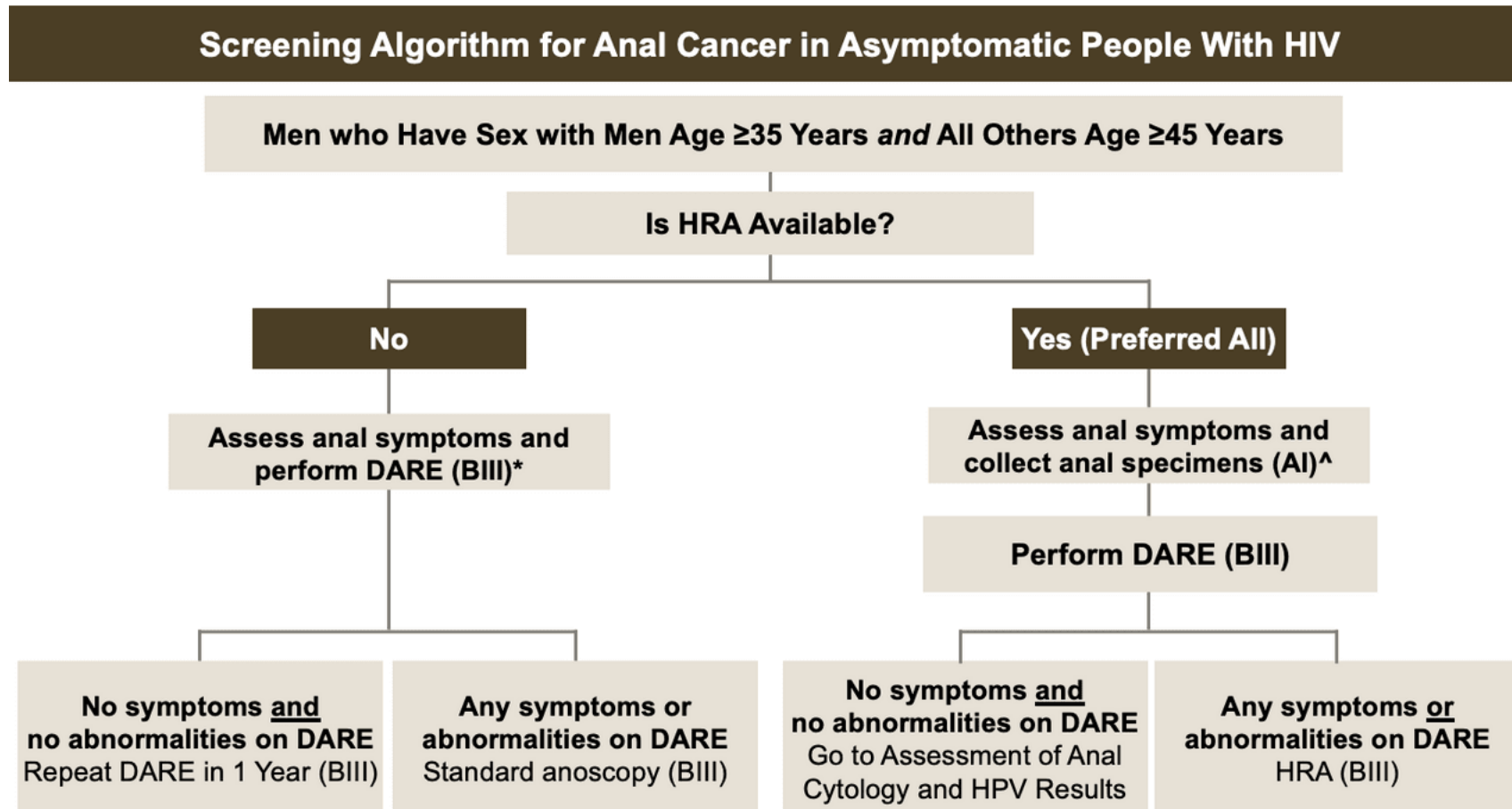
PROSTATE CANCER

CANCER SCREENINGS SPECIFICALLY IMPACTED BY HIV

ANAL CANCER

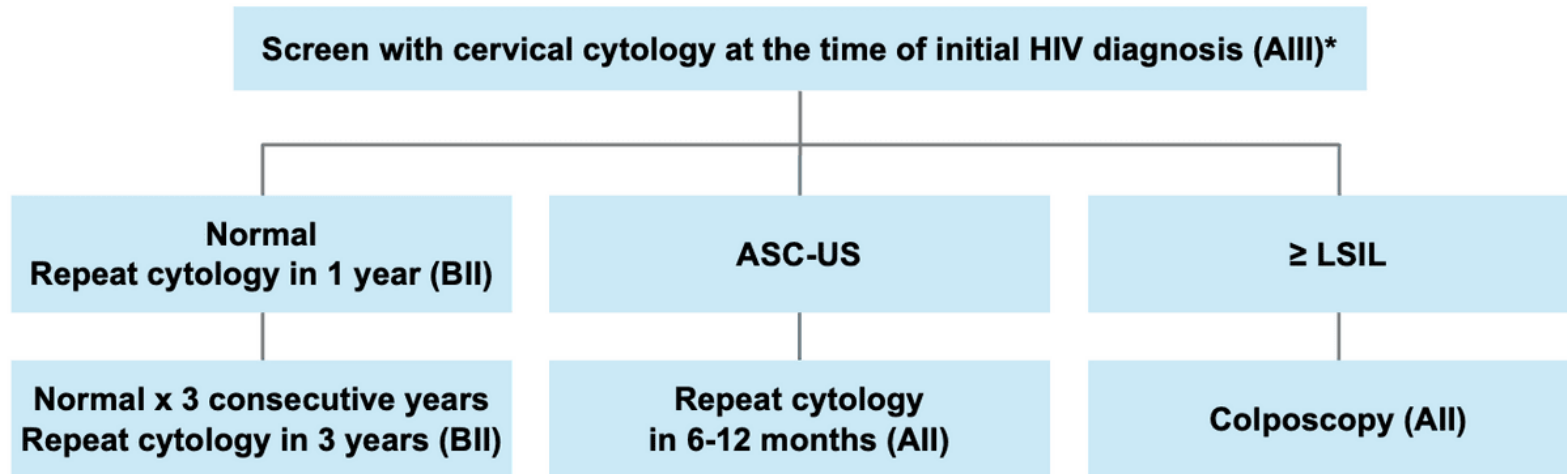
CERVICAL CANCER

ANAL CANCER SCREENING IN HIV



CERVICAL CANCER SCREENING IN HIV

Screening Algorithm for Cervical Cancer in Women With HIV Aged 21 to 29 Years



PRIMARY CARE MANAGEMENT

- Remember common ailments present commonly
- Opportunistic infections are rare in patients routinely engaged in care with stable CD4 counts
- Don't go Zebra hunting unless you've ruled out the dogs and cats



DIABETES MANAGEMENT IN PERSONS WITH HIV (ADA GUIDELINES)

- **Management of Diabetes:** in many cases, persons with HIV and mild blood glucose abnormalities can be effectively managed with lifestyle changes that include weight loss, increased exercise, and dietary modification
- **Monitoring Glycemic Status:** check 2x/year
 - The glycemic goal for nonpregnant adults is an HBA1c of less than 7% without significant hypoglycemia
 - The blood glucose target goal is to have greater than 70% of readings in the target range of 70-180 mg/dL
- **Screening for Renal Disease:** in addition to routine monitoring of kidney function, should have annual monitoring of urine albuminuria
- **Antiretroviral Therapy:** switching the antiretroviral regimen is not usually beneficial for impaired glucose tolerance – it is important to evaluate potential drug interactions
- **Use of Metformin and Antiretroviral Medications:** should be carefully monitored – concurrent use of metformin with dolutegravir or Bictegravir can increase the concentrations of metformin

HYPERTENSION

The 2017 ACC/AHA Hypertension Guideline revised the definition of hypertension as any systolic blood pressure of at least 130 mm Hg or any diastolic BP of at least 80 mm Hg

- Caution with calcium channel blockers and protease inhibitors
- Amlodipine, diltiazem, felodipine, nifedipine, and verapamil, in patients taking protease inhibitors or cobicistat, since these medications can raise levels of calcium channel blocker drugs
- EKG monitoring is recommended if a calcium channel blocker is used with either atazanavir or saquinavir

2017 American College of Cardiology/American Heart Association Clinical Practice Guidelines Categories of Blood Pressure for Adults			
Blood Pressure Category	Systolic		Diastolic
Normal	<120 mm Hg	and	<80 mm Hg
Elevated	120 – 129 mm Hg	and	<80 mm Hg
Hypertension Stage 1	130 – 139 mm Hg	or	80 – 89 mm Hg
Hypertension Stage 2	≥140 mm Hg	or	≥90 mm Hg

*Individuals with SBP and DBP in 2 categories should be designated to the higher BP category.

HYPERLIPIDEMIA

ROUTINE MONITORING OF LIPID PROFILES IN PEOPLE WITH HIV

The following summarizes recommendations for monitoring lipid profiles in people with HIV

- **Entry into Care:** At the time of entry into HIV care, a lipid profile should be ordered; if the test performed was a random lipid profile and it is abnormal, then a fasting lipid panel should be ordered
- **Antiretroviral Initiation or Modification:** A lipid profile should be ordered at the time of initiating or changing antiretroviral therapy
- **After Initiation or Modification of Antiretroviral Therapy:** Consider ordering a lipid profile 4 to 8 weeks after initiating or modifying antiretroviral therapy
- **Routine Monitoring:** If the lipid profile is abnormal or the person has cardiovascular risk, then monitoring should be conducted every 12 months. If the lipid profile remains normal and there is no cardiovascular risk, then monitoring should be every 5 years
- **Persons on Lipid-Lowering Therapy:** Persons receiving lipid-lowering therapy should have lipid monitoring individualized, and more frequent monitoring may be needed

HYPERLIPIDEMIA

PRIMARY PREVENTION OF ASCVD IN PEOPLE WITH HIV

The following summarizes recommendations in the Adult and Adolescent ART Guidelines for the use of statins in persons with HIV as primary prevention of ASCVD. Age 40-75 Years and Low-to-Intermediate (<20%) 10-Year ASCVD Risk Estimates:

- If ASCVD 5-20%, start at least moderate-intensity statin (AI)
 - Pitavastatin 4 mg orally once daily (AI), *or*
 - Atorvastatin 20 mg orally once daily (AII), *or*
 - Rosuvastatin 10 mg orally once daily (AIII)
- If ASCVD <5%, the guidelines favor starting at least moderate-intensity statin therapy, after shared decision-making, taking into account the presence or absence of HIV-related factors that can increase ASCVD risk (CI)
 - Pitavastatin 4 mg orally once daily (AI), *or*
 - Atorvastatin 20 mg orally once daily (AII), *or*
 - Rosuvastatin 10 mg orally once daily (AIII)
- Data are insufficient to recommend for or against statin therapy as primary prevention of ASCVD in persons younger than 40 years of age

OSTEOPOROSIS

SCREENING RECOMMENDATIONS FOR PERSONS WITH HIV

- All postmenopausal women with HIV and men 50 years of age and older with HIV should undergo bone mineral density screening with a DXA scan. Bone mineral density should also be assessed with a DXA scan in all adults with HIV who have a major risk factor for fragility fracture, including personal history of fragility fracture, chronic glucocorticoid treatment (greater than or equal to 5 mg of prednisone daily or equivalent for at least 3 months), or high risk of falls.
- In men with HIV 40 to 49 years of age and premenopausal women with HIV 40 years of age and older without a major risk factor for osteoporotic fracture, clinicians should assess fracture risk using the Fracture Risk Assessment Tool ([FRAX Calculation Tool](#)) specific to their country and the patient's race/ethnicity. Risk assessment should be performed every 2 to 3 years or when a new clinical risk factor develops. When using the FRAX tool, some experts recommend checking the "secondary osteoporosis" box to better adjust the estimate, considering the increased risk of osteoporosis conferred by HIV. A DXA scan should be performed if the FRAX tool determines the 10-year risk of major osteoporotic fracture to be greater than 10%.
- When interpreting DXA results, use T-scores for postmenopausal women and men 50 years of age and older and use Z-scores for persons younger than 50 years of age.
- Optimal screening intervals (for DXA or FRAX assessment) are not clear for persons with HIV. Consider repeating a DXA scan after 1 to 3 years for individuals who have advanced osteopenia (T-score -2.0 to -2.49) and after 4 to 5 years in those with mild-to-moderate osteopenia (T-score of -1.01 to -1.99); for those who have a normal DXA, guidance on when to repeat screening is not given, though some experts will repeat in 5 to 10 years.
- Vitamin D screening is recommended in all individuals with low bone mineral density or history of a fragility fracture; it should be considered in persons who have any of the major known risk factors for low vitamin D levels (e.g., dark skin, dietary deficiency, avoidance of sun exposure, malabsorption, obesity, chronic kidney disease, or treatment with regimens containing efavirenz).
- Routine measurement of serum or urine markers of bone turnover or inflammation for screening or treatment monitoring is not recommended for persons with HIV.
- **Treatment – avoid TDF if known osteoporosis – drug interactions are rare**



OLDER ADULTS WITH HIV/AIDS

- Currently, more than 50% of PLWH in the US are over age 50
- In 2021, 16% of new HIV diagnoses in the US were in people over age 50
- By 2030, over 70% of PLWH in the US will be over age 50
- Many PLWH who expected to live only a few years are alive and thriving
 - Geriatricians not trained in HIV
 - HIV Specialists without Geriatric Training
 - The role of PRIMARY CARE

MULTI-COMPLEXITY

- Comorbidities
- Comorbidities
- Comorbidities
- HIV is really the least of their problems



People worry about their health




Conditions they're worried about

Cancer	38%
Mental health condition	35%
Diabetes	31%
Heart disease	30%
Vision loss/vision deterioration	21%
Hereditary diseases	16%
Addictive behaviors	13%
Dementia/Alzheimer's	13%
Autoimmune diseases	13%
Hearing loss/hearing deterioration	13%
Sexually transmitted infections	7%
Other	4%
N/A: I prefer not to say	9%

HIV Symptom Evaluation Guides

Each *HIV Symptom Evaluation Guide* provides clinicians with a framework for evaluating certain common symptoms that individuals with HIV may experience. These guides offer a summary of important clinical questions and considerations, as well as decision trees to help with the evaluation process.

 Download All Guides 

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<https://www.hiv.uw.edu/page/symptom-evaluation/guides>

GUESS WHAT?

- Current Guideline: all patients aged 13-64 should receive HIV testing at least one time in their life
- Condom use
- PrEP and PEP access for partners
- STI testing
- Meds for menopause symptoms and hypogonadism
- Erectile Dysfunction

People don't stop having sex when diagnosed with HIV

TOBACCO CESSATION

FDA-Approved Recommended Medications for Tobacco Cessation Treatment*

Drug (doses)	How Sold (U.S.)	Dosing Instructions	Administration	Common Side Effects	Advantages	Disadvantages
Nicotine patch 21 mg 14 mg 7 mg	OTC or Rx	Starting dose: 21 mg for ≥10 cigarettes per day. 14 mg for <10 cigarettes per day. After 6 weeks, option to taper to lower doses for 2-6 weeks. Use ≥3 months. After 6 weeks, continue original dose or taper to lower doses (either option acceptable).	Apply a new patch each morning to dry skin. Rotate application site to avoid skin irritation. May start patch before or on quit date. Keep using even if a slip occurs. If insomnia or disturbing dreams, remove patch at bedtime.	Skin irritation Trouble sleeping Vivid dreams (patch can be removed at bedtime to manage insomnia or vivid dreams)	The easiest nicotine product to use. Provides a steady nicotine level. Combination NRT therapy, as needed, can add gum, lozenge, inhaler, or nasal spray to patch to cover situational cravings.	User cannot alter dose if cravings occur during the day.
Nicotine lozenge 4 mg 2 mg	OTC or Rx	If first cigarette is ≤30 minutes of waking: 4 mg. If first cigarette is >30 minutes of waking: 2 mg. Use ≥3 months.	Place between gum and cheek, let it melt slowly. Use 1 piece every 1-2 hours (Max: 20/day).	Mouth irritation Hiccups Heartburn Nausea	User controls nicotine dose. Oral substitute for cigarettes. May be added to patch to cover situational cravings. Easier to use than gum for those with dental work or dentures.	No food or drink 15 minutes prior to use and during use.
Nicotine gum 4 mg 2 mg	OTC or Rx	If first cigarette is ≤30 minutes of waking: 4 mg. If first cigarette is >30 minutes of waking: 2 mg. Use ≥3 months.	Chew briefly until mouth tingles, then 'park' gum inside cheek until tingle fades. Repeat chew-and-park each time tingle fades. Discard gum after 30 minutes of use. Use - 1 piece per hour (Max: 24/day).	Mouth irritation Jaw soreness Heartburn Hiccups Nausea	User controls nicotine dose. Oral substitute for cigarettes. May be added to patch to cover situational cravings.	Not chewed in same way as regular gum; requires careful instruction. Can damage dental work and be difficult to use with dentures. No food or drink 15 minutes prior to use and during use.
Nicotine inhaler 10 mg cartridge	Rx only	10 mg/cartridge. Each cartridge has ~80 puffs. Use ≥3 months.	Puff into mouth/throat until cravings subside. Do not inhale into lungs. Change cartridge when nicotine taste disappears. Use 1 cartridge every 1-2 hours (Max: 16/day).	Mouth and throat irritation Coughing if inhaled too deeply	User controls nicotine dose. Mimics hand-to-mouth ritual of smoking cigarettes. May be added to patch to cover situational cravings.	Frequent puffing required.
Nicotine nasal spray 10 mg/mL (10 mL bottle)	Rx only	10 mg/mL. 0.5 mg per spray. Each bottle has ~200 sprays. Use ≥3 months.	Use 1 spray to each nostril. Use spray every 1-2 hours (Max: 80/day).	Nasal and throat irritation Rhinitis Sneezing Coughing Tearing	User controls nicotine dose. Most rapid delivery of nicotine among all NRT products. May be added to patch to cover situational cravings.	Has the most side effects of all NRT products. Some users cannot tolerate local irritation to nasal mucosa.
Varenicline (tablet) 0.5 mg 1.0 mg	Rx only	Days 1-3: 0.5 mg/day. Days 4-7: 0.5 mg twice a day. Day 8+: 1 mg twice a day. Use 3-6 months.	Start 1-4 weeks before quit date. Take with food and a tall glass of water to minimize nausea.	Nausea Insomnia Vivid dreams Headache	Quit date can be flexible, from 1 week to 3 months after starting drug. Dual action: relieves nicotine withdrawal and blocks reward of smoking. Oral agent (pill).	Because of previous FDA warning (now removed), many patients fear psychiatric adverse events, even though they are no more common than with other cessation medications.
Bupropion sustained release (SR) (tablet) 150 mg	Rx only	150 mg/day for 3 days, then 150 mg twice a day. Use 3-6 months.	Start 1-2 weeks before quit date.	Insomnia Agitation Dry mouth Headache	May lessen post-cessation weight gain while drug is being taken. Oral agent (pill).	Increases seizure risk; not for use if seizure disorder or binge drinking.

* All are FDA-approved as smoking cessation aids and listed as a first-line medication by U.S. Clinical Practice Guidelines (Forness, 2008)

+ Recommended duration of use for medications is at least 3 months but extending dose to 6 months is frequently done to prevent relapse to tobacco use. Patching dosing differs slightly from FDA labeling.

Abbreviations: FDA = U.S. Food and Drug Administration; NRT = nicotine replacement therapy; OTC = over the counter (no prescription required); Rx = prescription required.



SUBSTANCE USE: SUMMARY POINTS

- Substance use disorders are common among adults with HIV in the United States.
- Many substance use disorders in people with HIV are linked to decreased retention in care, reduced adherence to antiretroviral medications, and lower rates of virologic suppression.
- Combining psychosocial interventions with pharmacotherapy (acamprosate, disulfiram, oral naltrexone, or extended-release naltrexone injection) is the optimal approach for treating alcohol use disorder; all pharmacotherapies can be used to treat persons with HIV, keeping in mind that disulfiram has several clinically significant drug interactions with antiretroviral medications whereas acamprosate and naltrexone do not.
- There is a high rate of cannabis use among persons with HIV, and treatment for cannabis use disorders should focus on behavioral therapies.
- The use of methamphetamines and "club drugs" (e.g., hallucinogens and ecstasy) is significant among bisexual men and men who have sex with men, including those with HIV.
- Behavioral strategies are the primary intervention for stimulant and hallucinogen use disorders, although there is increasing evidence to support the use of mirtazapine or the combination of bupropion plus injectable naltrexone for persons with methamphetamine use disorder.
- The rise in opioid addiction has paralleled the rise in opioid prescribing habits over the past several decades; tackling the opioid epidemic will require educating clinicians and patients alike about the risks, benefits, and proper role of opioid pain medications.
- Medications for opioid use disorder are necessary and highly effective for the treatment of opioid use disorder, and options include opioid agonists (methadone), opioid partial agonists (buprenorphine), and, though less effective, opioid antagonists (naltrexone).
- Among persons with HIV who inject opioid drugs, both drug- and HIV-related mortality are lower when antiretroviral therapy and medications for opioid use disorder are prescribed jointly.
- Treatment strategies for substance use disorders should embrace a harm reduction philosophy in order to best serve those individuals at the highest risk for ongoing substance use.

LOW-BARRIER CARE MODEL TABLE

Category	Component	Rationale	Examples
Structural Elements	Walk-in access to care	Removes a central barrier to completing clinic visits	All visits (medical care and case management) available without scheduled appointments
Structural Elements	Integrated care team with case managers	Addresses social needs as a core part of care delivery	Case managers build relationships with patients; low-caseload medical case management; nonmedical case management
Structural Elements	Incentives	Encourages engagement and helps meet immediate needs	Cash incentives (e.g., for blood draws, viral suppression); gift cards; food, clothing, hygiene items
Process-of-Care Elements	Low-barrier care philosophy	Aligns care with patient priorities and real-world constraints	Shortened/streamlined visits; harm-reduction approach to substance use; sequencing interventions; minimizing medications; flexible treatment plans
Process-of-Care Elements	Expanded primary care scope	Reduces fragmentation and reliance on specialty care	PCPs manage complex conditions; fewer referrals; network of specialists willing to see walk-in patients
Process-of-Care Elements	Multisector coordination	Addresses external factors that influence health outcomes	Coordination with housing agencies, jail release planners, adherence programs, methadone programs, behavioral health services
Process-of-Care Elements	Commitment to rapid modification	Ensures the model adapts to patient needs and local context	Pilot programs; iterative improvement; incorporating feedback; abandoning ineffective strategies; flexible policies



National HIV PrEP Curriculum

www.hivprep.uw.edu

APP: HIV PREP TOOLS FOR CLINICIANS

This app supports health care professionals to:

- Evaluate persons for HIV PrEP
- Identify appropriate HIV PrEP medications
- View recommended laboratory tests
- Assess, initiate, and monitor HIV PrEP

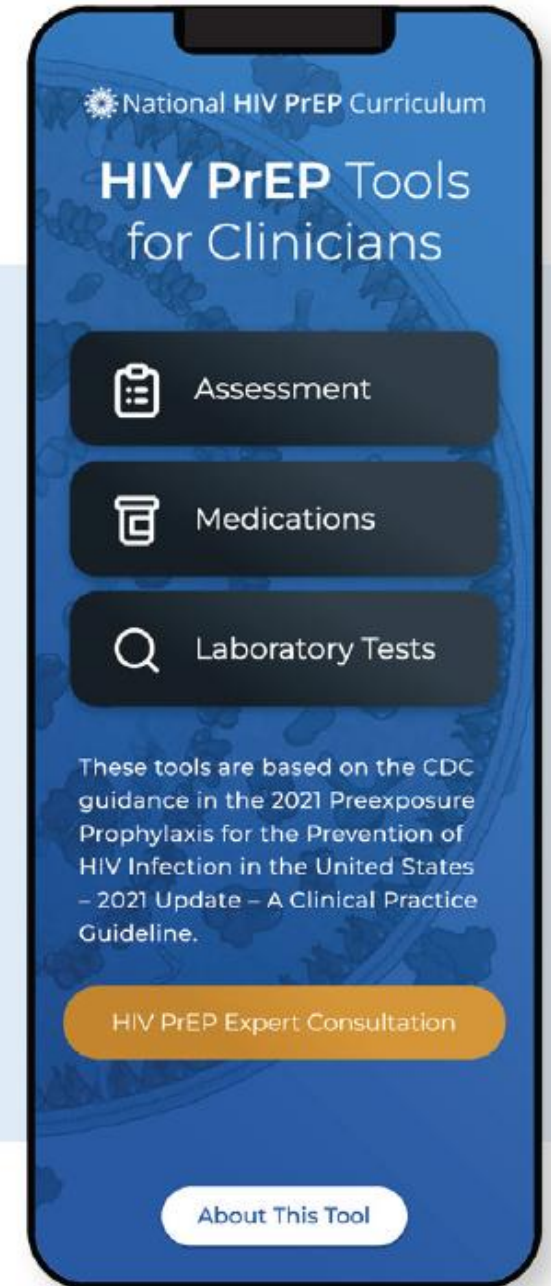
Access the app on a web browser (hiv.prep.uw.edu/page/tools/app), via the CDC STI Tx Guide app, or download the free app



APPLE APP STORE



GOOGLE PLAY



University of Washington (UW) Professor of Medicine Dr. David Spach is Editor-in-Chief of this site and four other curricula about HIV, 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).



National HIV PrEP Curriculum

Free, up-to-date website for healthcare professionals to learn how to assess, initiate, and monitor HIV PrEP



www.hivprep.uw.edu

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

VISIT THE SITE TO:

- Access 10 **Self Study lessons**, earn free CE and CoC, and track progress
- Scroll through **Quick Reference lessons** to find answers
- Earn **HIV PrEP Training Certificate** by completing fundamentals module and assessment
- Use **HIV PrEP Tools for Clinicians app** to assess then determine medications and lab tests
- Watch clinically relevant **Mini-Lectures** to supplement learning
- Examine **HIV PrEP Clinical Guides** about medication options, on-demand dosing, & lab tests
- Create free **learning groups** to invite members, assign content, and track progress

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.

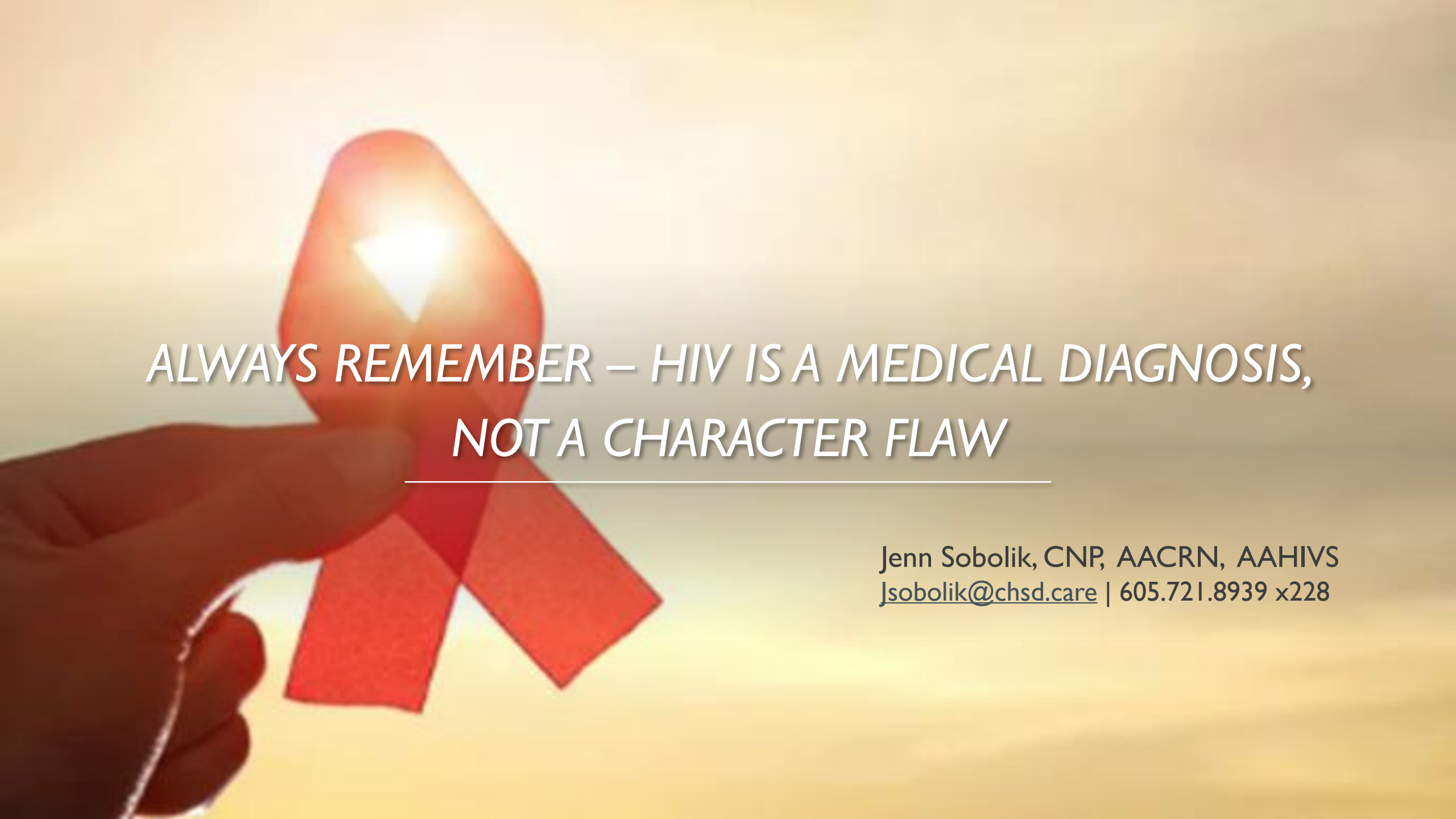
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Free, up-to-date website for healthcare professionals to learn about HIV diagnosis, treatment, and prevention

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- 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

A hand is shown holding a red HIV awareness ribbon. The background is a warm, golden-yellow gradient with a bright light source creating a lens flare effect behind the ribbon. The text is centered over the image.

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

Jenn Sobolik, CNP, AACRN, AAHIVS
jsobolik@chsd.care | 605.721.8939 x228