FLOWCHART 1: Initial Visit: New Patient, New HIV Diagnosis, NOT Taking ART

Available at: **hivguidelines.org/hiv-primary-care**

CLINICAL GUIDELINES PROGRAM

First visit with a new patient who has a new HIV diagnosis and is NOT taking ART

Note: Treat or refer for emergency care when a patient has red flag symptoms, e.g., fevers, dyspnea, severe headaches, mental status changes.

Confirmed HIV diagnosis:

- Assess HIV treatment readiness and facilitate shared decision-making regarding ART (see NYSDOH AI guideline Rapid ART Initiation > Benefits and Risks of ART)
- Recommend and offer same-day or rapid ART
- **If the patient is not ready to start ART:** Schedule a return visit within 1 week to allow the patient time to process the new diagnosis, then recall as needed to reassess treatment readiness

Unconfirmed HIV diagnosis:

- Explain the diagnosis confirmation process and order confirmatory HIV testing; see the standard HIV testing algorithm
- Assess HIV treatment readiness, recommend and facilitate shared decision-making regarding same-day or rapid ART; discuss harm reduction [a], including transmission prevention
- If the patient is taking PrEP, manage per the recommendations in the NYSDOH AI guideline PrEP to Prevent HIV and Promote Sexual Health

All patients:

Obtain:

- Pronoun(s) and gender identity
- Patient concerns and goals
- Standard medical, surgical, and family histories
- Standard ROS and physical exam, including sex organ inventory
- Current medications; note potential drug-drug interactions
- Immunization status

Provide counseling and patient education:

- ART options and benefits of ART, including rapid start and U=U
- HIV transmission prevention [a]
- HIV disclosure status
- Age-, sex-, and risk-based screening and preventive care recommendations, including immunizations
- Adherence requirements and support resources
- Substance use treatment and harm reduction options
- Sexual health, including condom use, STI prevention, and other harm reduction options (e.g., doxy-PEP)

Assess (also see Checklist 1)**:**

- Comorbidities
- Symptoms of common opportunistic infections (PJP, TB, CMV, CM); initiate OI prophylaxis if the patient's CD4 count is <200 cells/mm^3
- Substance use, including tobacco; if high-risk, engage in shared decision-making regarding SUD treatment
- Harm reduction knowledge and needs
- Functional status
- Urgent psychosocial or behavioral needs
- Trauma experience, including medical trauma

Order:

- Baseline laboratory testing
- Seasonal and other priority vaccines, e.g., influenza, COVID-19, mpox, pneumococcal; avoid live vaccines in patients with CD4 count <200 cells/mm^3
- STI and other indicated age-, sex-, and risk-based screening and preventive care if not available on site

Refer, as indicated, for:

- Imaging
- Urgent specialty care
- Assistance with urgent psychosocial needs
- Screening and preventive care that cannot be provided on site

Follow-up:

After ART is initiated:

- **1 week after, in-person visit:** Review laboratory test results, including confirmatory HIV test result; assess and manage adverse effects and adherence challenges
- **2 weeks after, in-person, telephone, or telemedicine visit:** Assess and manage adverse effects and adherence challenges
- **4 weeks after, in-person visit:** Assess and manage adverse effects and adherence challenges; assess for symptoms of IRIS; identify drug-drug interactions; order HIV viral load testing
  - Continue immunizations until the patient has received all indicated vaccines; avoid live vaccines until CD4 count is >200 cells/mm^3
  - Assess [b]: Comorbidity management, preventive and specialty care needs, psychosocial status and urgent psychosocial needs
  - Provide counseling, as above
- **HIV viral load and comprehensive metabolic panel:**
  - 4 weeks after ART initiation
  - At least every 8 weeks until complete virologic suppression is documented
- **CD4 cell count:**
  - 12 weeks after ART initiation
  - Every 4 months until CD4 count >200 cells/mm^3 is obtained on 2 measurements at least 4 months apart, then at least every 6 months if CD4 count is ≤350 cells/mm^3
  - Optional if CD4 count is >350 cells/mm^3 and viral load is suppressed, i.e., <20 to <50 copies/mL
  - See NYSDOH AI guideline Virologic and Immunologic Monitoring in HIV Care

If rapid ART is not initiated:

- **1 week after the first visit, in-person:** Review laboratory test results, including confirmatory HIV test result
  - Reassess treatment readiness and barriers
  - Engage the patient in motivational interviewing and shared decision-making regarding ART initiation
  - Provide counseling, as above
- **Ongoing:** Schedule return visits to encourage ART initiation, monthly or at intervals that respect the patient's autonomy and at a frequency that the patient agrees to

Abbreviations: ART, antiretroviral therapy; CM, cryptococcal meningitis; CMV, cytomegalovirus; doxy-PEP, doxycycline post-exposure prophylaxis; HBV, hepatitis B virus; HCV, hepatitis C virus; HPV, human papillomavirus; IRIS, immune reconstitution inflammatory syndrome; OI, opportunistic infection; PEP, post-exposure prophylaxis; PJP, *pneumocystis jirovecii* pneumonia; PrEP, pre-exposure prophylaxis; ROS, review of systems; STI, sexually transmitted infection; SUD, substance use disorder; TB, tuberculosis; U=U, undetectable=untransmittable.

Notes:

a. Ongoing discussion and education regarding HIV disclosure, U=U, PrEP and PEP for sex partners, and harm reduction is recommended.

b. Ongoing surveillance for diseases transmitted through the same routes as HIV, including HCV, HBV, HPV, and other STIs, is recommended.