BASELINE EVALUATION

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Every person with HIV entering into care should have a complete medical history, physical examination, and laboratory evaluation performed, and should be counseled regarding HIV. The medical history should also include any history of antiretroviral (ARV) use for pre-exposure prophylaxis (PrEP) or post-exposure prophylaxis. The goals of this initial evaluation are to confirm the diagnosis of HIV, obtain appropriate baseline historical and laboratory data, ensure patient understanding about HIV and its transmission, and initiate care as recommended in the HIV Medicine Association of the Infectious Diseases Society of America's (HIVMA/IDSA) Primary Care Guidance Update for Providers Who Care for Persons With HIV[1] and the Adult and Adolescent Opportunistic Infections Guidelines.[2] The initial evaluation also should include discussion of the benefits of antiretroviral therapy (ART) for the patient's health and to prevent HIV transmission, as well as strategies to optimize care engagement and treatment adherence **(AIII).** Information obtained in this baseline evaluation can then be used to define treatment management goals and plans. The Panel on Antiretroviral Guidelines for Adults and Adolescents recommends initiating ART at the time of diagnosis or as soon as feasible to increase the uptake of ART, decrease the time required to achieve linkage to care and virologic suppression, improve the rate of virologic suppression, and reduce HIV transmission **(AII).**

The following laboratory tests and physical assessments performed during initial patient visits can be used to assess HIV-related conditions and other comorbidities, and assist in the selection of ARV regimens (see Laboratory Testing):

- HIV antigen/antibody testing (if prior documentation is not available or if HIV RNA is below the assay's limit of detection)
- CD4 T lymphocyte (CD4) cell count
- Plasma HIV RNA (viral load)
- Complete blood count; chemistry profile, including glucose, blood urea nitrogen and creatinine, liver enzymes and bilirubin, and urinalysis
    - If random blood glucose level is abnormal, fasting glucose should be obtained.
- Serum lipids (if random levels are abnormal, fasting lipids should be obtained)
- Hepatitis A, B, and C virus serologies
- Genotypic drug-resistance testing **(AII).** Standard genotypic drug-resistance testing involves testing for mutations in the reverse transcriptase and protease genes. If transmitted integrase strand transfer inhibitor (INSTI) resistance is suspected or if the person has ever used long-acting cabotegravir as PrEP or received an INSTI-based regimen for post-exposure prophylaxis, genotypic resistance testing also should include the integrase gene (see Drug-Resistance Testing).
    - In people with confirmed HIV RNA levels between 201 copies/mL and 500 copies/mL, drug-resistance testing may not be successful but should still be considered (see Drug-Resistance Testing).
- HLA-B*5701 test (if abacavir is being considered)
- Screening tests for sexually transmitted infections (STIs), opportunistic infections, and cancer should be performed as recommended in the HIVMA/IDSA's Primary Care Guidance Update for

Providers Who Care for Persons With HIV[1] and the Adult and Adolescent Opportunistic Infections Guidelines.[2]

- Height, weight, and the corresponding body mass index
- Pregnancy testing (for those with reproductive potential), if not already performed

Many clinics have adopted a rapid start policy to initiate ART on the day of HIV diagnosis in order to increase ART uptake and engagement in care and accelerate the time to viral suppression. Rapid ART initiation also reduces the time during which people with newly diagnosed HIV can transmit HIV. It is critical to outline a clear plan for a comprehensive clinical visit soon after ART initiation, especially for people without a reliable contact method. Rapid ART initiation is appropriate for most people with newly diagnosed HIV. Most laboratory tests discussed above should be obtained prior to ART initiation, but the test results need not be available before the first prescription of ART. Below are some considerations regarding key test results.

- **HIV RNA and CD4 Count:** HIV RNA will provide information on pretreatment viral load, and CD4 count will determine the need for prophylaxis against certain opportunistic infections (see Adult and Adolescent Opportunistic Infections Guidelines).[2]
- **Laboratory Testing (e.g., complete blood count, renal function tests, liver enzymes):** A clinician should review the results as soon as possible.
- **Genotypic Resistance Testing:** Results should be reviewed as soon as possible with adjustments of the ART regimen, if needed (see What to Start and Drug-Resistance Testing).
- **Viral Hepatitis Screening:** If results are pending, a regimen with activity against hepatitis B virus (i.e., tenofovir alafenamide or tenofovir disoproxil fumarate with emtricitabine or lamivudine) should be selected (see What to Start and Hepatitis B Virus/HIV Coinfection).
- **STI Screening:** Testing should be ordered at the initial visit, with results reviewed as soon as possible.

People with HIV often must cope with many social, psychiatric, and medical issues that are best addressed through a patient-centered, multidisciplinary approach. The baseline evaluation should include consideration of the person's readiness and commitment for lifelong ART, including an assessment of substance use (including tobacco use), social support, mental health, medical comorbidities, economic factors (e.g., unstable housing, food instability), medical insurance status and adequacy of coverage, and other factors that are known to impair adherence to ART and increase the risk of HIV transmission (see Table 20 in Adherence to the Continuum of Care). Once evaluated, these factors should be managed accordingly. The baseline evaluation also should include a discussion of risk reduction and disclosure to sexual and/or needle-sharing partners, especially for people not on ART, due to ongoing risk of HIV transmission. People with HIV should be informed that maintaining a plasma HIV RNA level of <200 copies/mL with ART, including any measurable value below this threshold, prevents sexual transmission of HIV to their partners **(AII).** This concept may be recognized as Undetectable = Untransmittable or U=U.

For previously treated patients who present for an initial evaluation with a new health care provider, it is critical to obtain a complete ARV history (including drug-resistance testing results, if available), preferably through the review of past medical records. Understanding why the person with HIV is changing to a new health care provider is also critical to support engagement in care and ART adherence.

In the rare occasion that a person with HIV declines to initiate or reinitiate ART, it is critical to encourage regular follow-up (e.g., every 3–6 months) with a clinical provider and other available

services. Benefits of ART should be discussed at all visits. Table 4 in the Laboratory Testing section provides guidance for laboratory monitoring if ART is deferred.

References

1. Horberg M, Thompson M, Agwu A, et al. Primary care guidance for providers of care for persons with human immunodeficiency virus: 2024 update by the HIV Medicine Association of the Infectious Diseases Society of America. *Clin Infect Dis*. 2024:1-57. Available at: https://www.ncbi.nlm.nih.gov/pubmed/39393187.

2. Panel on Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents With HIV. Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV. 2026. Available at: https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-opportunistic-infections/whats-new.