Best Practice Solutions to HIV Prevention at Health Centers Community of Practice Session 1: Provider Knowledge and Comfort

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NATIONAL LGBTQIA+ HEALTH EDUCATION CENTER
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Agenda

- Opening and intros
- Overview of the current HIV prevention/PrEP landscape
- Utilizing the GOALS framework to take a sexual history-Activity

Our Roots

Fenway Health

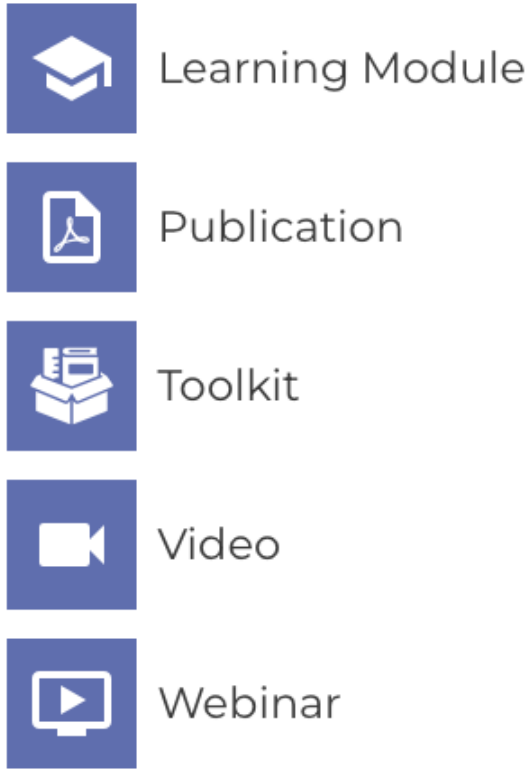
- Independent 501(c)(3) FQHC
- Founded 1971
- Mission: To enhance the wellbeing of the LGBTQIA+ community as well as people in our neighborhoods and beyond through access to the highest quality health care, education, research, and advocacy
- Integrated primary care model, including HIV and transgender health services

The Fenway Institute

- Research, Education, Policy

The National LGBTQIA+ Health Education Center

- Training and Technical Assistance
- Grand Rounds
- Online Learning
  - CE and HEI Credit
- Environmental Influences On Child Health Outcomes (ECHO) Programs
- Publications and Resources



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- Alternatively, e-mail us at education@fenwayhealth.org for less urgent questions.

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- Choose “I will call in”
- Dial the phone number and access code

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Other Health Professionals	Confirm equivalency of credits with relevant licensing body.

Ice Breaker and Intros!

- Let's get to know each other!
- Please use the tool on your screen to grab a sticky note and tell us:
  - Your name and pronouns
  - Role and organization
  - State you are joining from
  - Your favorite dessert or treat!

An overview of the current HIV prevention landscape

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Disclosures

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Learning objectives

1. Describe the current range of HIV prevention/PrEP options, and the advantages and disadvantages of each option.
2. Summarize how recent advances in HIV prevention/PrEP may facilitate prescribing and uptake.
3. Discuss peer-to-peer strategies to increase clinician buy-in about prescribing PrEP.

The 30,000-foot view

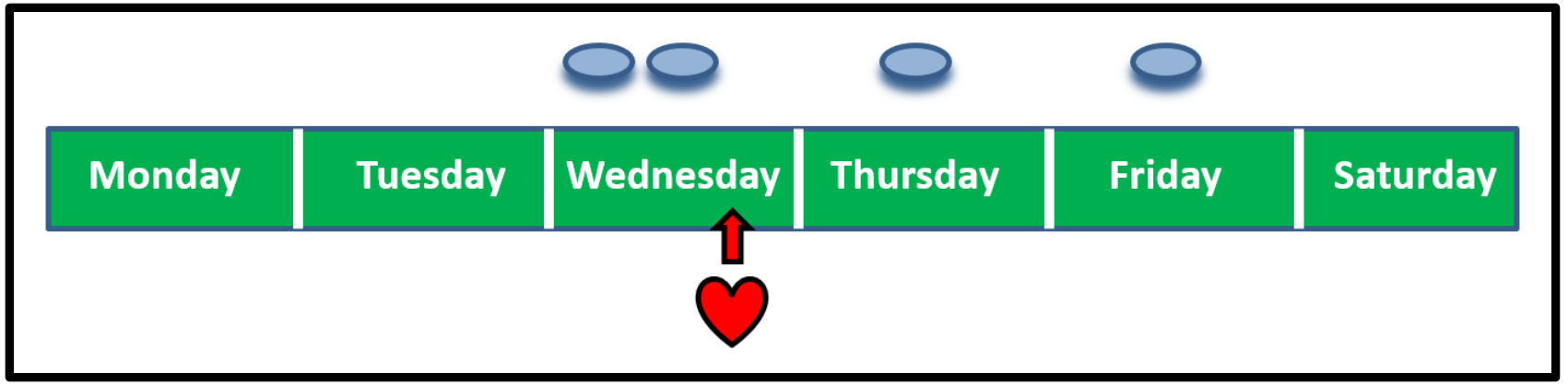
4 FDA-approved options for PrEP			
2 oral options		2 injectable options	
TDF/FTC	TAF/FTC	CAB	LEN
Daily (or on-demand) dosing	Daily dosing	Every-2-month injections	Every-6-month injections

TDF/FTC

- **Evidence:** Prevents HIV acquisition through sex and injection drug use; efficacy has been demonstrated among a broad range of people
- **Dosing:** One tablet (emtricitabine [FTC] 200 mg and tenofovir disoproxil fumarate [TDF] 300 mg) once daily*
- **Advantages:**
  - Longest clinical experience among PrEP agents, including in pregnancy
  - Available as a generic
  - Can be used in an on-demand fashion by MSM*
- **Disadvantages:**
  - Renal toxicity and decreased bone mineral density
  - Requires baseline hepatitis B testing

On-demand TDF/FTC (“2-1-1”)

- Considered an alternative for MSM without chronic hepatitis B
- With TDF/FTC only; no published data with other PrEP agents
- Prescribe no more than 30 tablets at a time before retesting for HIV
- Follow the same laboratory monitoring strategy as for daily oral TDF/FTC

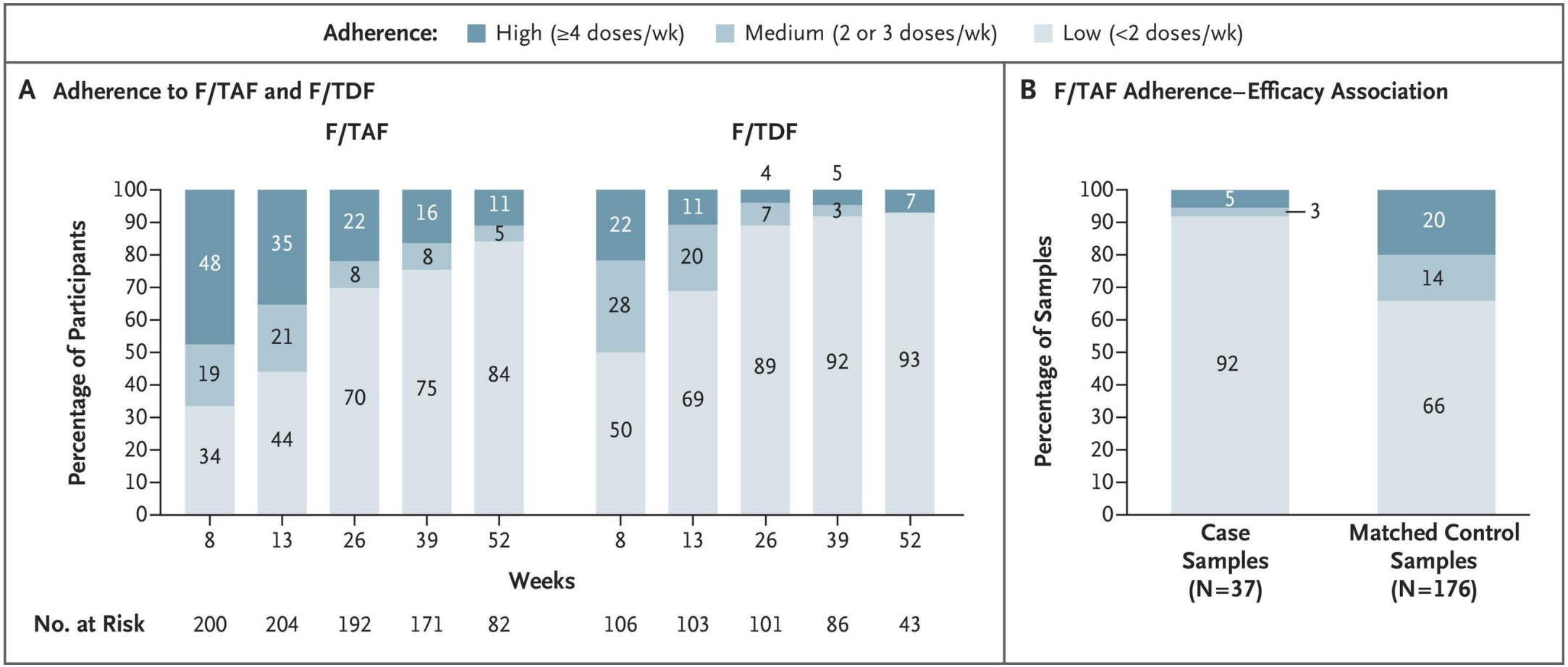


Centers for Disease Control and Prevention: US Public Health Service: Preexposure prophylaxis for the prevention of HIV infection in the United States – 2021 update: a clinical practice guideline. 2021. Available at: https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.pdf.

TAF/FTC

- **Evidence:** Prevents HIV acquisition through sex; non-inferior to TDF/FTC among MSM
- **Dosing:** One tablet (emtricitabine [FTC] 200 mg and tenofovir alafenamide [TAF] 25 mg) once daily
- **Advantages:**
  - Fewer renal and bone effects in comparison to TDF/FTC
- **Disadvantages:**
  - Efficacy data are more limited for people who have receptive vaginal sex
  - Has mild deleterious effects on lipids and weight
  - Requires baseline hepatitis B testing

TAF/FTC prevents HIV among women with high adherence.



Bekker LG, N Engl J Med, 2024

Cabotegravir (CAB)

- **Evidence:** Prevents HIV acquisition through sex; superior to TDF/FTC for PrEP among MSM, women, and others
- **Dosing:**
  - Cabotegravir 600 mg intramuscularly once monthly for 2 doses, then every 2 months
  - An oral lead-in phase of cabotegravir 30 mg once daily prior to the first injection is optional
- **Advantages:**
  - Obviates the need for daily pill adherence
  - Superior to TDF/FTC for PrEP in a range of populations
- **Disadvantages:**
  - Injection site reactions are common, although often mild
  - Benefits navigation may be time-consuming
  - Same-day initiation may not be possible currently
  - Implications of the medication's tail phase
  - If HIV occurs despite CAB, HIV test interpretation may be challenging

Lenacapavir (LEN)

- **Evidence:** Prevents HIV acquisition through sex among a broad range of people
- **Dosing:**
  - Lenacapavir 927 mg subcutaneously every 26 weeks (+/- 2 weeks)
  - Lenacapavir 600 mg by mouth daily for 2 days with initiation of the drug
- **Advantages:**
  - Infrequent dosing interval
  - Superior to TDF/FTC for PrEP in a range of populations
  - Can be used in pregnancy
- **Disadvantages:**
  - Injection site reactions are common, although often mild
  - Benefits navigation may be time-consuming
  - Same-day initiation may not be possible currently
  - Implications of the medication's tail phase
  - Drug-drug interactions

Considerations for selecting an agent for PrEP

What do they prefer?	Comorbidities	Nature of HIV exposure	Logistics
Which PrEP agent do they want, and why?	Renal or bone disease favors TAF/FTC, CAB, or LEN	Evidence for the role of TAF/FTC for people who have receptive vaginal sex is more limited	A desire for telehealth/limited in-person visits favors oral PrEP
	Hepatitis B favors oral PrEP	TDF is the only agent studied among people who inject drugs thus far	On-demand dosing favors TDF/FTC
	Hyperlipidemia, weight concerns favor TDF/FTC		Same-day initiation favors oral PrEP
	Drug-drug interactions may complicate use of CAB or LEN		Insurance considerations may favor a specific agent

Several recent developments facilitate PrEP provision.

- Expansion of choices facilitates uptake.
  - Patients are more likely to find an option that appeals to them.
  - It would be extremely uncommon for someone to have medical contraindications to all forms of PrEP.
- Population-based constraints on PrEP are diminishing (e.g., all drugs are considered options for women; CAB and LEN are being studied among people who inject drugs).
- A generic option is available (TDF/FTC).
- Clear guidelines are available from the IAS-USA and CDC.
- There is a move to less frequent monitoring for people taking PrEP.

Every-6-month STI testing is non-inferior to every-3-month testing among MSM.

- **Population:** 428 MSM taking PrEP in the Netherlands
- **Design:** Randomized trial of STI screening every 3 or 6 months
- **Outcomes:** Additional visits rates and STI positivity
- **Results:**
  - Overall, the visit rate was lower in the 6-month group, though additional STI visits were more frequent
  - There was no difference in STI positivity between groups (22% in the 6-month group and 21% in the 3-month group, P=0.35)

Bruinderink MLG, et al. Abstract 3295. AIDS 2024.

Peer-to-peer strategies to facilitate PrEP prescribing

- Foster a PrEP champion who
  - Can coach colleagues as they begin to offer PrEP
  - Can provide PrEP consultation around initiation or questions that arise during PrEP management
- Situate PrEP within the context of primary care:
  - PrEP is primary prevention!
  - PrEP is like other common sexual health interventions, such as contraception.
  - PrEP management is more straightforward than many other aspects of primary care, including management of hypertension and diabetes.
  - PrEP provides a gateway to receipt of other primary care services – e.g., vaccination, health screenings, etc.

Summary

- There are currently four medications available for PrEP: TDF/FTC, TAF/FTC, CAB, and LEN.
- Expansion of PrEP choices, the availability of a generic option, and steps to ease monitoring on PrEP may all foster increased uptake of this intervention.
- Peer champions can play a crucial role in facilitating PrEP provision.

Utilizing the GOALS framework to take a sexual history

DR. WHITNEY IRIE

GOALS framework for sexual history taking

A structured approach to creating safe conversations about sexual health in routine clinical care. GOALS helps both medical and non-medical members build trust, encourage disclosure, and support patient-driven prevention.

Give a preamble

Normalize sexual health as routine care, not a response to risk

Offer opt-out testing

Make HIV/STI testing universal, not conditional conditional on disclosure

Ask open-ended questions

Let patients guide the conversation with their their own language

Listen actively

Fill in only what's clinically needed—avoid unnecessary probing

Suggest next steps

Offer benefit-based recommendations without judgment

Source: https://www.hivguidelines.org/guideline/goals-framework/

Two approaches: what makes the difference?

✓ GOALS-aligned approach

Provider: "I ask all my patients about sexual health as part of routine care. I'd like to offer HIV and STI testing today—you can decline if you prefer. To help me understand what testing makes sense, can you tell me about your sex life these days?"

Patient: "Well, I've been seeing someone new for a few months..." months..."

Provider: "Thanks for sharing. What kinds of sex are you having together?"

This opens dialogue, normalizes the conversation, and lets the patient patient lead with their own language.

✗ Common missteps

Provider: "Are you sexually active? How many partners have you had in the past year?"

Patient: "Um... one?"

Provider: "Are you using protection? Any risky behaviors I should should know about?"

Patient: "We're safe."

This approach uses closed questions, assumes risk language, and limits what patients feel comfortable sharing.

The quality of sexual history taking *is* the intervention. How we ask shapes trust, disclosure, and readiness for prevention.

Breakout room role-play activity

You'll practice GOALS-based sexual history taking in small groups. This is about exploring how the conversation *flows*—not achieving clinical perfection. Expect awkward moments; they're part moments; they're part of the learning.

1

Provider role

Initiate a sexual history using all five GOALS steps during a routine visit. Focus on open-ended questions and language—not risk assessment or partner counts.

- Use a normalizing preamble
- Listen more than you talk
- Suggest next steps without judgment

2

Patient role

You're here for routine care, not a sexual health concern. Answer honestly using everyday language, but language, but don't volunteer extra details unless asked asked with curiosity and care.

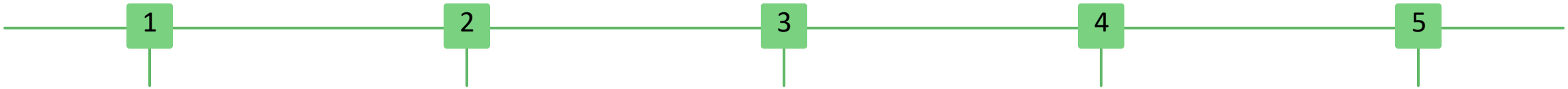
- Respond briefly to closed questions
- Share more with open-ended prompts
- Notice how language affects your comfort

3

Observer role (optional)

Listen for where conversation flows or stalls. Track Track language that opens or closes dialogue. Help name Help name patterns during the group debrief.

- Note moments of connection
- Identify awkward transitions
- Observe non-verbal cues



Round 1: Role play

3–4 minutes of practice

Round 1: Debrief

2–3 minutes reflection

Round 2: Role play

3–4 minutes (switch roles)

Round 2: Debrief

2–3 minutes reflection

Large group reflection reflection

Return to main room

Ready to practice

What to remember

- GOALS is about flow, not checklists

  You're practicing how it feels to have these conversations, not memorizing scripts.

- Missteps are useful

  Notice what makes conversations stall—that's where the learning happens.

- This is just the sexual history

  We'll discuss connections to PrEP and prevention when we reconvene as a full group.

- Psychological safety matters

  Be curious, not critical. Support each other's growth through honest, kind reflection.

Total activity time

30 minutes in breakout rooms

10–15 minutes large group reflection and PrEP bridge bridge discussion

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Your facilitator will guide timing and support your group throughout the activity.

Activity reflection

- Where did it feel smooth?
- Where did it get awkward or stall?

Closing

- Next Session: 1/29/26, 2 pm ET

HRSA Disclaimer

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