HIV Primary Care Essentials—An Ounce of Prevention Is Worth a Pound of Cure



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Financial Relationships With Ineligible Companies (Formerly Described as Commercial Interests by the ACCME) Within the Last 2 Years

Dr Wooten reported no relevant financial relationships with ineligible companies. (Updated October 15, 2026)

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Learning Objectives

After attending this presentation, learners will be able to:

- Compare different models of HIV primary care
- Identify key components of comprehensive care for people with HIV
- Apply current recommendations for vaccinations, cancer screenings, and sexually transmitted infection prevention for people with HIV
- Describe cardiovascular-kidney-metabolic syndrome and mitigating interventions for people with HIV

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Outline

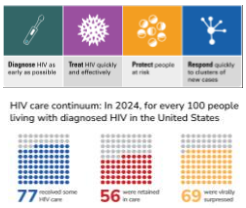
- HIV Primary Care Models
- Preventive Care Highlights
  - Vaccines
  - Screenings
  - Prevention of Cardiovascular Kidney Metabolic syndrome

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Why HIV Primary Care Matters in 2026

Ending the HIV epidemic

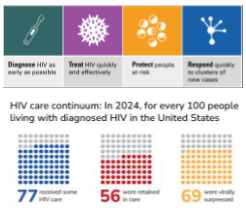


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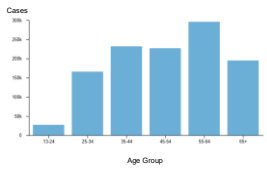
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Why HIV Primary Care Matters in 2026

Ending the HIV epidemic



Supporting a growing population aging with HIV



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The Great Debate: Different Models of HIV Primary Care

1. HIV Specialist as the PCP
   - HIV clinician (often ID-trained) provides comprehensive care, including HIV and other primary care services
   - Delivered in specialized HIV clinics
   - Consolidated, continuous care; requires HIV specialists to maintain knowledge of general medicine (with support from subspecialists as appropriate)
2. Combined Care
   - HIV specialist provides HIV care, PCP manages other primary care issues
   - Patients receive care from experts within their fields (HIV, primary care)
   - Requires communication and care coordination
3. Non-HIV Specialist as the PCP
   - Traditional PCP manages all HIV and primary care needs
   - Consolidated, continuous care; delivered in primary care settings, expanding access
   - Requires additional training and support for more complex HIV cases

Chida N. Clin Infect Dis. 2026;83(1):e54–e67. Gruber CJ, et al. Clin Infect Dis. 2026;83(1):e50–e53.

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HIV Outcomes Similar Across Provider Type

- 6,323 US adults receiving HIV care
- June 2019 – May 2021
- **NO** difference in most outcomes between ID and non-ID providers
  - ART prescription
  - Sustained virologic suppression
  - Satisfaction with care
  - Provider trust
- Slightly better retention in care and completion of STI screening among non-ID providers

Weiser J, et al. J Acquir Immune Defic Syndr. 2024;96:180–189.

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Shortage of ID, HIV, and Primary Care Clinicians





- 3.6 ID physicians / 100,000 individuals
- 79.5% of counties have no ID physicians

Massive shortage of PCPs

Health Resources and Services Administration (HRSA). Health Professional Shortage Areas (HPSA) Map Gallery. Available at: https://data.hrsa.gov/topics/health-workforce/shortage-areas/map-gallery-hpsa. Accessed October 2026.

Maarsel J, et al. Open Forum Infect Dis. 2024;11:ofae208.

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What does excellent HIV primary care look like?

Preventive Care
- ✓ Vaccinations
- ✓ Cancer screenings
- ✓ Other screenings

Chronic Disease Care
- ✓ Cardiometabolic health
- ✓ Kidney & bone health
- ✓ Multimorbidity management
- ✓ Minimize polypharmacy

Sexual Wellness
- ✓ STI screening, prevention
- ✓ U=U
- ✓ Reproductive and gender health

Health Promotion
- ✓ Nutrition
- ✓ Physical activity
- ✓ Management of tobacco, alcohol, recreational drug use

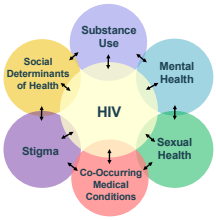
Durable, virologic suppression

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Syndemics in HIV Primary Care

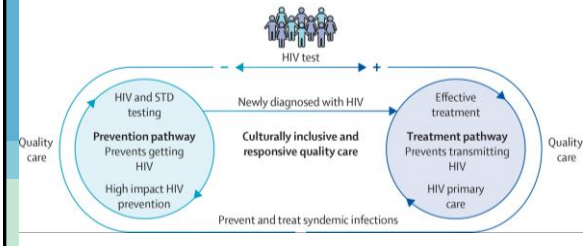
Syndemics (synergistic epidemics):
- interconnected health and social conditions
- interact and amplify each other
- lead to poorer health outcomes



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Status-Neutral Approach



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Outline

- HIV Primary Care Models
- Preventive Care Highlights
  - **Vaccines**
  - Screenings
  - Prevention of Cardiovascular Kidney Metabolic syndrome

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Challenges with Vaccine Recommendations

- CDC/ACIP recommendations no longer reliable
- IDSA, AAP, ACOG, DHHS OI guidelines remain reliable
- CIDRAP / Vaccine Integrity Project provide evidence syntheses for various vaccines

CIDRAP. Vaccine Integrity Project. University of Minnesota. https://vaxintegrity.cidrap.umn.edu/. Accessed October 8, 2026.
NIH/HIVMA/IDSA. Guidelines for Opportunistic Infections in Adults and Adolescents With HIV. clinicalinfo.hiv.gov. Accessed October 8, 2026
Hoehens MA, Thompson MB, Avery A, et al. Clin Infect Dis. 2024;xiae479. doi:10.1093/cid/ciae479

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Vaccinations for People with HIV

Contraindicated

Avoid in all people with HIV

- ACAM2000 smallpox
- Live attenuated influenza vaccine
- Oral typhoid TY21a

Avoid if CD4 <200

- MMR
- Varicella
- Yellow fever

Routinely Recommended

- COVID-19
- Influenza
- Hepatitis A
- Hepatitis B
- MenACWY
- Pneumococcal
- Tdap/Td
- Recombinant zoster

Age / Risk-Based

- HPV: Through age 26, shared decision-making ages 27-45
- MenB: Specific risk indication
- Mpox: Sexual exposure risk; OK at any CD4
- RSV: >75 yrs, 50-74 yrs + high-risk conditions

NIH/HIVMA/IDSA. Guidelines for Opportunistic Infections in Adults and Adolescents With HIV. clinicalinfo.hiv.gov. Accessed October 8, 2026
Hoehens MA, Thompson MB, Avery A, et al. Clin Infect Dis. 2024;xiae479. doi:10.1093/cid/ciae479

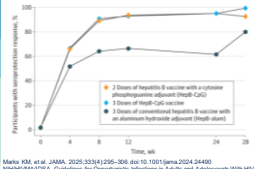
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Hepatitis B Vaccines and Serologies

Bee-HIVe RCT

2-dose HepB-CpG vaccine is more immunogenic than standard HepB vaccine



Marks KM, et al. JAMA. 2025;333(4):295–306. doi:10.1001/jama.2024.24400

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Isolated anti-HBc Positivity

- Given single dose of HepB vaccination
- Check anti-HBs in 1-2 mo
  - >100 mIU/mL, no further vaccination is needed
  - <100 mIU/mL, complete vaccination series

Switching to a tenofovir-sparing regimen

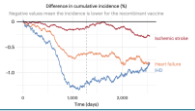
- Low risk of HBV reactivation if isolated anti-HBc positivity OR if positive for both anti-HBc and anti-HBs
- Monitor LFTs q3 mo for 6mo and then q6 mo thereafter

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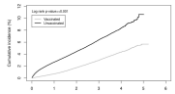
Shingles Vaccination

- Recombinant zoster
  - Non-live subunit, adjuvanted vaccine
- All adults with HIV ≥18 years of age
- No CD4 cutoff

Reduction in cardiovascular outcomes



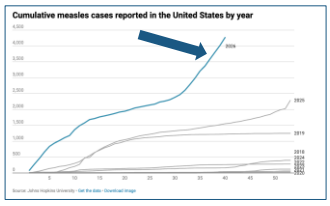
Reduction in dementia



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Measles



- MMR contraindicated if CD4<200 OR pregnant
- CD4 ≥200, born in US ≥1957 and no written documentation of MMR OR lack evidence of immunity:

VACCINATE!!!

(2 doses MMR, 1 mo apart)

HCPs without documented immunity get 2 doses

NIH/HIVMA/IDSA. Guidelines for Opportunistic Infections in Adults and Adolescents With HIV. clinicalinfo.hiv.gov. Accessed October 8, 2026.

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  - Vaccines
  - **Screenings**
  - Prevention of Cardiovascular Kidney Metabolic syndrome

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Cancer Screenings (not impacted by HIV)

	USPSTF Recommendations
Prostate	Shared decision-making; annual PSA (+/- DRE)
	Age 55-69 (USPSTF), Age 50 or Age 40-45 & high-risk (Am Cancer Society)
Breast	Mammogram every other year (annually per American Cancer Society)
	Age 40-74
Colon	1) FIT annually, 2) FIT-fecal DNA q3 yrs, or 3) Colonoscopy q10 yrs
	Age 45-75
Lung	Annual low-dose CT with >20 pack-yr history and still smoking (or quit within past 15 yrs)
	Age 50-80

USPSTF. *JAMA*. 2018;319:1901-1913. doi:10.1001/jama.2018.3710;USPSTF. *JAMA*. 2024;331:1918-1930. doi:10.1001/jama.2024.5534;USPSTF. *JAMA*. 2021;325:1965-1977. doi:10.1001/jama.2021.6238;USPSTF. *JAMA*. 2021;325:962-970. doi:10.1001/jama.2021.1117

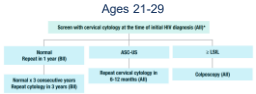
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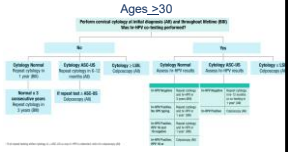
HPV-Related Cancer Screenings in PWH

Cervical Cancer Screening

Ages 21-29



Ages >30



Differences in screening from the general population:

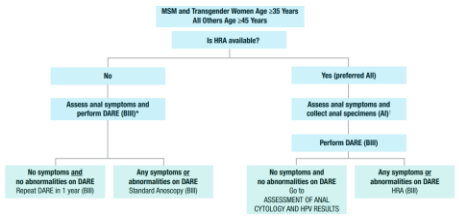
- Limited HPV co-testing in young individuals given high prevalence of HPV in PWH
- Longest interval for screening is 3 years (not 5 years)
- Screening continues lifelong (vs age 65)

Hsu KK, Thompson MA, Aberg JA, et al. Clin Infect Dis. 2024;xxx:ciae479. doi:10.1093/cid/ciae479. NIH/HIVMA/IDSA Guidelines for Opportunistic Infections in Adults and Adolescents With HIV.

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HPV-Related Cancer Screenings in PWH

Anal Cancer Screening



NIH/HIVMA/IDSA. Guidelines for Opportunistic Infections in Adults and Adolescents With HIV. clinicalinfo.hiv.gov. Accessed October 8, 2026.

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Additional Screenings

Bone Density	DEXA scan
	Post-menopausal women, men age >50 years
Oral Health	Dental health exam/cleaning, twice a yea
	All adults
Abdominal aortic aneurysm screening	Abdominal ultrasound
	Men ages 65-75 who have ever smoked

STI Screening:
- Gonorrhea, chlamydia, syphilis at least annually from all exposed sites
  - q3-6 mo for individuals with higher exposure
- Trichomonas annually for individuals with receptive vaginal sex
- HBV, HCV screening annually for MSM, transgender women

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Doxycycline Post-Exposure Prophylaxis (DoxyPEP)

- Cisgender MSM or transgender women
  - SFDPH recommends for cisgender women
- Bacterial STI in past 12 mo
- Shared decision-making



IPERGAY OLE (France)	DoxyPEP (San Francisco, Seattle)
• RCT doxy PEP vs placebo • 232 MSM, TGW on daily oral HIV PrEP • **Decreased risk of chlamydia (70%), syphilis (73%)** • No impact on risk of gonorrhea	• RCT doxy PEP vs placebo in MSM, TGW • 174 PWH, 327 PWoH on HIV PrEP • **Decreased risk of chlamydia, syphilis, gonorrhea** • NNT to prevent 1 STI quarterly = 4.7 in PWoH, 5.5 in PWH
ANRS DOXYVAC (France)	**dPEP (Kenya)**
• RCT doxy PEP vs placebo • 577 MSM on HIV PrEP • Stopped early due to efficacy • **Significant reductions in chlamydia, syphilis, gonorrhea**	• RCT doxy PEP vs placebo • 449 cisgender women • **No risk reduction** in chlamydia, gonorrhea; too few cases of syphilis • Low adherence (~29%) by hair sample

Molina et al. *Lancet Infect Dis.* 2018. Luetkemeyer et al. *NEJM.* 2023. Molina et al. *Lancet Infect Dis.* 2024. Stewart et al. *NEJM.* 2023.

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Outline

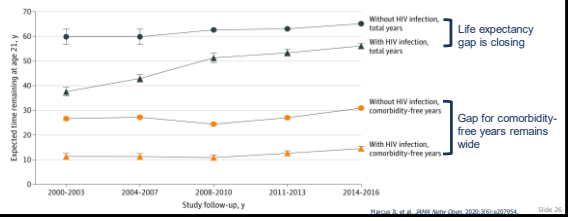
- HIV Primary Care Models
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  - **Prevention of Cardiovascular Kidney Metabolic syndrome**

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Risk of cardiometabolic disease in PWH

Matched cohort 39,000 PHW and 387,785 PWoH

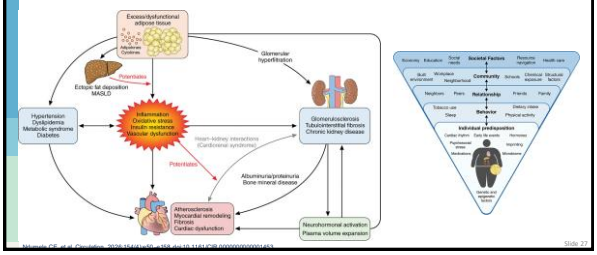


Marcus JL, et al. JAMA Netw Open. 2020;3(6):e207954.

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Cardiovascular-Kidney-Metabolic Syndrome



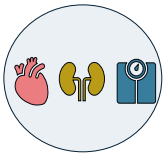
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Prevention and Treatment CKM Syndrome

Prevention

- Annual BP, BMI, **waist circumference**
- Routine lipids, glycemia, eGFR
- Routine assessment of **SDOH**
- If obese, **sleep apnea screening**
- If pre-DM/DM, **FIB-4 (MASLD)**
- UACR if indicated



Treatment

- Multimodal management of obesity
- Cardioprotective glucose-lowering therapy
- BP control
- Renal protective agents
- Lipid lowering therapies

Who should receive a statin for primary prevention?

PWH age 40-75 years: Recommend statin therapy for primary prevention

Ndumele CE, et al. Circulation. 2026;154(5):e1–e134. doi:10.1161/CIR.0000000000001433

Blumenthal RS, et al. 2026 ACC/AHA Guideline on the Management of Dyslipidemia. Circulation. 2026;153(4):e268–e346. doi:10.1161/CIR.0000000000001251

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