Health Care Provider Experiences After 12 Months of Implementing Cabotegravir Long-Acting Injectable PrEP (CAB LA) for Black Women: EBONI Study Results

Poster THPEE096

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- **In EBONI, clinics serving Black women tripled their capacity to provide long-acting cabotegravir (CAB LA) over 12 months.**
- **Healthcare providers (HCPs) used implementation resources (e.g. clinic readiness checklist, acquisition tracker) and strategies (e.g. flexible scheduling) to help integrate CAB LA into their clinics.**
- **HCPs reported ancillary benefits of visits every 2 months (Q2M), including additional opportunities to screen for sexually transmitted infections (STIs)/comorbidities and providing other health/psychological care.**
- **HCPs felt that CAB LA was very appropriate for Black women and found the regimen to be highly acceptable and feasible.**

Introduction

- Black women account for ~50% of new HIV diagnoses among cisgender and transgender women in the United States (US).[1,2]
- CAB LA administered Q2M via intramuscular injection is the first approved LA agent for pre-exposure prophylaxis (PrEP).[3,4]
- EBONI (NCT05514509) is a 12-month, Phase 4, real-world effectiveness–implementation hybrid study evaluating implementation strategies for the delivery of CAB LA for HIV PrEP to adult Black cis- and transgender women across infectious disease, primary care, and women's health clinics in "Ending the HIV Epidemic" jurisdictions in the US.
- We present implementation outcomes and ancillary health benefits from the perspective of HCPs after 12 months of CAB LA use in the EBONI study.

Methods

- Twenty-three clinics were randomized 1:1:1 into:
  - Standard implementation (SI): standard of care.
  - Enhanced implementation (EI): standard of care and provider support (e.g. PrEP communications tool).
  - Enhanced collaborative implementation (ECI): standard of care and provider/patient support (e.g. PrEP materials for patients).
- Quantitative data were collected via self-completed electronic surveys from HCPs on their experiences implementing CAB LA for Black women in their clinics at baseline, Month 4, and Month 12.
  - HCPs evaluated the appropriateness, acceptability, and feasibility of CAB LA using the validated Intervention Appropriateness Measure (IAM), Acceptability of Intervention Measure (AIM), and Feasibility of Intervention Measure (FIM) questionnaires, respectively.[5]
  - Surveys were analyzed using descriptive statistics.
- Qualitative interviews were conducted with a sample of HCPs.
  - Interview topics were guided by the Consolidated Framework for Implementation Research and Proctor implementation outcomes taxonomy[6,7] and analyzed using a framework analysis approach.

Results

- From August 2022 to February 2025, 84 HCPs across 15 clinics completed surveys, 52 of whom also completed qualitative interviews.
- Most HCPs (55%) were cisgender females, 49% were Black, and 12% were Hispanic, with a mean age of 44 years (**Table 1**).

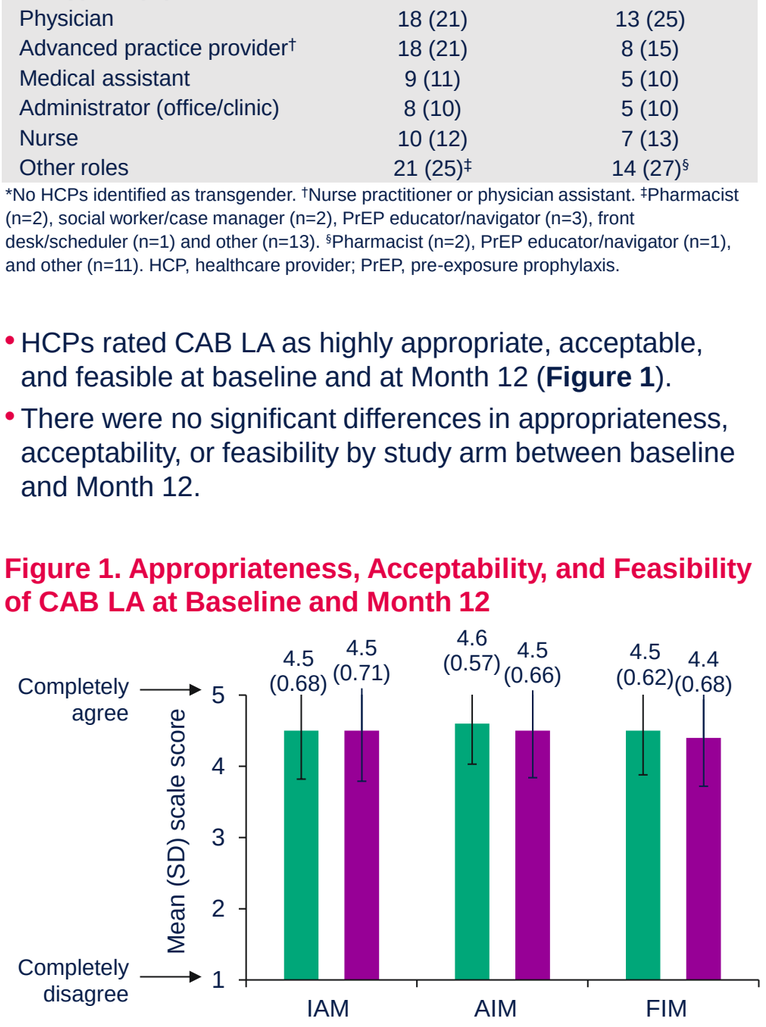
Table 1. Demographic Characteristics at Month 12

Parameter (EBONI)	Quantitative sample (N=84)	Qualitative sample (N=52)
Gender identity, n (%)*		
Cisgender male	26 (31)	15 (29)
Cisgender female	46 (55)	33 (63)
Nonbinary	1 (1)	0
Other	4 (5)	1 (2)
Prefer not to answer	7 (8)	3 (6)
Race, n (%)		
Asian	3 (4)	2 (4)
Black	41 (49)	23 (44)
Mixed race	4 (5)	1 (2)
Native American	0	0
White	26 (31)	19 (37)
Other race	4 (5)	4 (8)
Prefer not to answer	6 (7)	3 (6)
Ethnicity, n (%)		
Hispanic/Latinx	10 (12)	6 (12)
Not Hispanic/Latinx	67 (80)	43 (83)
Prefer not to answer	7 (8)	3 (6)
Role type, n (%)		
Physician	18 (21)	13 (25)
Advanced practice provider†	18 (21)	8 (15)
Medical assistant	9 (11)	5 (10)
Administrator (office/clinic)	8 (10)	5 (10)
Nurse	10 (12)	7 (13)
Other roles	21 (25)‡	14 (27)§

*No HCPs identified as transgender. †Nurse practitioner or physician assistant. ‡Pharmacist (n=2), social worker/case manager (n=2), PrEP educator/navigator (n=3), front desk/scheduler (n=1) and other (n=13). §Pharmacist (n=2), PrEP educator/navigator (n=1), and other (n=11). HCP, healthcare provider; PrEP, pre-exposure prophylaxis.

- HCPs rated CAB LA as highly appropriate, acceptable, and feasible at baseline and at Month 12 (**Figure 1**).
- There were no significant differences in appropriateness, acceptability, or feasibility by study arm between baseline and Month 12.

Figure 1. Appropriateness, Acceptability, and Feasibility of CAB LA at Baseline and Month 12



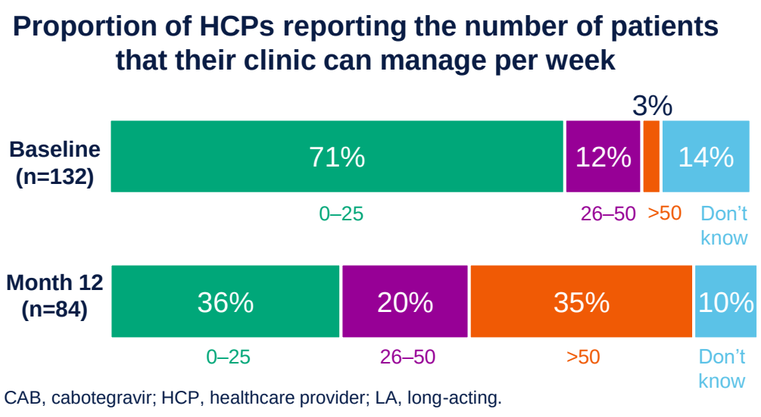
Measures are rated on a 1–5 Likert scale: 1 = "completely disagree"; 2 = "disagree"; 3 = "neither agree nor disagree"; 4 = "agree"; 5 = "completely agree".
AIM, Acceptability of Intervention Measure; CAB, cabotegravir; FIM, Feasibility of Intervention Measure; IAM, Intervention Appropriateness Measure; LA, long-acting; SD, standard deviation.

> ***"CAB LA, I think, has met my expectations 100%. I have patients that have been able to maintain an HIV-negative status while on the medication. [It] is easy and most patients like it."*** **(EI, advanced practice provider)**

> ***"It's greatly exceeded my expectations. Mine and I think the patients as well. It's another tool in the toolbox for prevention."*** **(ECI, nurse)**

- The number of patients receiving CAB LA that clinics could manage per week increased from Month 1 to Month 12, with clinic capacity to accommodate >25 patients tripling by Month 12 (15% vs. 55%) (**Figure 2**).
- Notably, this increase in clinic capacity was achieved with:
  - A decrease in the mean (SD) number of staff needed to incorporate CAB LA (baseline, 4.4 [5.05]; Month 12, 3.8 [3.55]).
  - A minority of HCPs reporting that their clinics required >40% of a full-time equivalent staff member's time to incorporate CAB LA in their clinics (baseline, 17%; Month 12, 20%).
- Clinic capacity to accommodate >25 patients was consistent across study arms at baseline (15%) but differed at Month 12 (SI, 46%; EI, 62%; ECI, 56%).

Figure 2. Number of Patients Receiving CAB LA That Clinics Can Manage Per Week

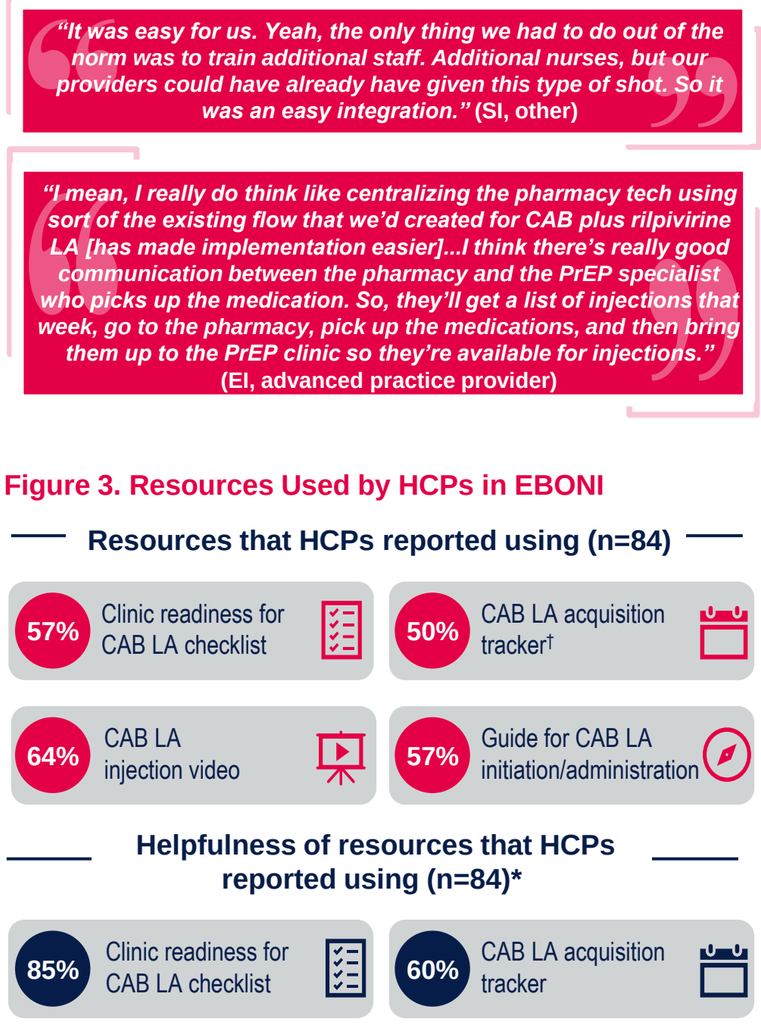


CAB, cabotegravir; HCP, healthcare provider; LA, long-acting.

> ***"It was easy for us. Yeah, the only thing we had to do out of the norm was to train additional staff. Additional nurses, but our providers could have already have given this type of shot. So it was an easy integration."*** **(SI, other)**

> ***"I mean, I really do think like centralizing the pharmacy tech using sort of the existing flow that we'd created for CAB plus rilpivirine LA [has made implementation easier]...I think there's really good communication between the pharmacy and the PrEP specialist who picks up the medication. So, they'll get a list of injections that week, go to the pharmacy, pick up the medications, and then bring them up to the PrEP clinic so they're available for injections."*** **(EI, advanced practice provider)**

Figure 3. Resources Used by HCPs in EBONI

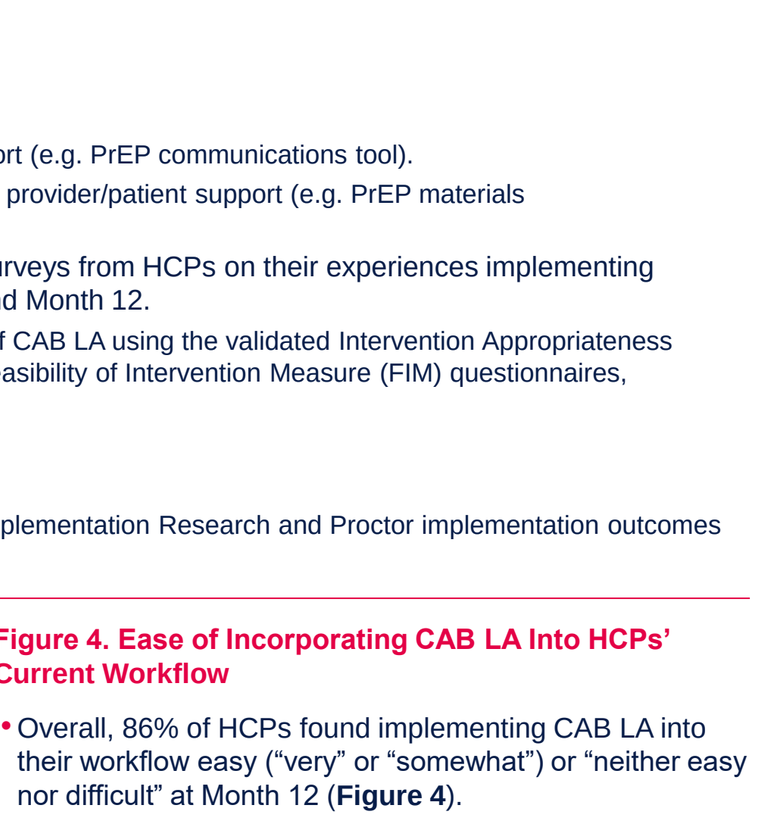


*Percentages reflect the proportion of participants who reported "very helpful" or "somewhat helpful" out of those participants who reported using each resource.
†n=10, CAB LA acquisition tracker was only available to participants in the EI arm.
CAB, cabotegravir; EI, enhanced implementation; HCP, healthcare provider; LA, long-acting; PrEP, pre-exposure prophylaxis.

- HCPs reported high use (50–64%) and helpfulness (60–93%) of the resources shown in **Figure 3**.
- HCPs also reported using flexible scheduling (e.g. drop-in [5–19%], before- or after-hour appointments [4–11%]), training on providing PrEP to Black women, and partnering with speciality pharmacies to acquire CAB LA.

Figure 4. Ease of Incorporating CAB LA Into HCPs' Current Workflow

- Overall, 86% of HCPs found implementing CAB LA into their workflow easy ("very" or "somewhat") or "neither easy nor difficult" at Month 12 (**Figure 4**).



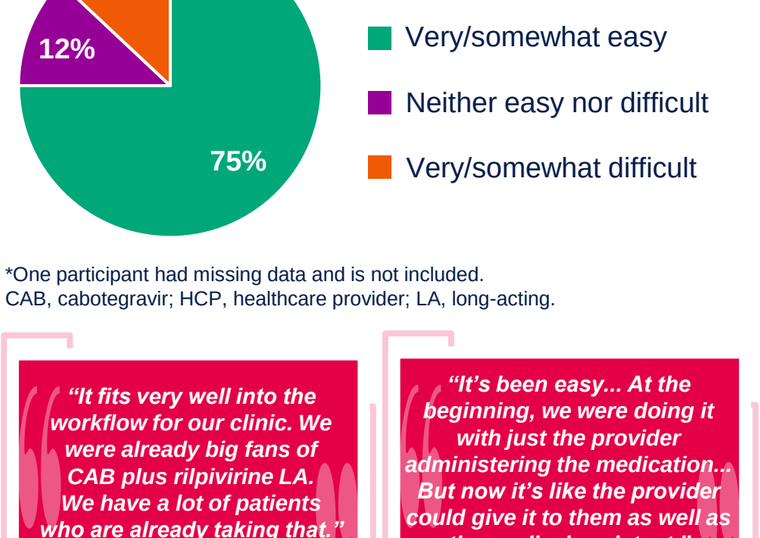
*One participant had missing data and is not included.
CAB, cabotegravir; HCP, healthcare provider; LA, long-acting.

> ***"It fits very well into the workflow for our clinic. We were already big fans of CAB plus rilpivirine LA. We have a lot of patients who are already taking that."*** **(EI, admin)**

> ***"It's been easy... At the beginning, we were doing it with just the provider administering the medication... But now it's like the provider could give it to them as well as the medical assistant."*** **(ECI, other medical professional)**

- HCPs noted benefits of Q2M visits for CAB LA injections, including additional screenings for sexually transmitted infections (73%), screening for comorbidities (49%), and providing other health/psychological care (36%) (**Figure 5**).

Figure 5. Benefits of Q2M Visits for CAB LA Injections*



*Month 12 data (n=83, one participant had missing data).
CAB, cabotegravir; LA, long-acting; PrEP, pre-exposure prophylaxis; Q2M, every 2 months; STI, sexually transmitted infection.

> ***"…I think it's been super beneficial only because the patients are required to come in. Patients get more frequent, testing for STIs, which is critical... And if you are on oral PrEP, they may spend months without getting, coming in for a visit."*** **(SI, other medical professional)**

Conclusions

- Within a year, clinic capacity to provide CAB LA tripled with a decrease in the number of total staff needed per week to incorporate CAB LA into their clinic.
- CAB LA can be integrated into various clinic types to expand PrEP access for Black women by using implementation resources (e.g. clinic assessment tools) and strategies (e.g. flexible appointments).
- HCPs in women's health, primary care, and infectious disease clinics found CAB LA highly appropriate for Black women, with visits Q2M offering ancillary health benefits, including additional opportunities to screen for STIs.

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