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GOALS Framework for Sexual History Taking in Primary Care

Updates, Authorship, and Related Resources

Date of current publication	September 26, 2023
Intended users	Primary care clinicians providing sexual health care
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Author conflict of interest disclosures	There are no author conflict of interest disclosures.
Date of original publication	July 30, 2019
Developer and funder	New York State Department of Health AIDS Institute (NYSDOH AI)
Development process	See Supplement: Guideline Development and Recommendation Ratings
Related NYSDOH AI resources	**Podcast** • Viremic—Cases in HIV

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Background: Sexual history taking can be an onerous and awkward task that does not always provide accurate or useful information for patient care. Standard risk assessment questions (e.g., *How many partners have you had sex within the last 6 months?*; *How many times did you have receptive anal sex with a man when he did not use a condom?*) may be alienating to patients, discourage honest disclosure, and communicate that the number of partners or acts is the only component of sexual risk and health.

In contrast, the GOALS framework is designed to streamline sexual history conversations and elicit information most useful for identifying an appropriate clinical course of action. The "goal" of the GOALS framework is to reimagine the sexual history to make it easier and more productive for providers and patients.

The GOALS framework was developed in response to 4 key findings from the sexual health research literature:

1. Universal HIV/STI screening and biomedical prevention education is more beneficial and cost-effective than risk-based screening[Eckman, et al. 2021; Keenan, et al. 2020; Lancki, et al. 2018; Hull, et al. 2017; Hoots, et al. 2016; Owusu-Edusei, et al. 2016].
2. Emphasizing benefits—rather than risks—is more successful in motivating patients toward prevention and care behavior[Reynolds-Tylus 2019; Epton, et al. 2015; Sheeran, et al. 2014; Weinstein and Klein 1995].
3. Positive interactions with healthcare providers promote engagement in prevention and care[Howe, et al. 2019; Flickinger, et al. 2013; Alexander, et al. 2012; Bakken, et al. 2000].
4. Patients want their healthcare providers to talk with them about sexual health[Agochukwu-Mmonu, et al. 2021; Zhang, et al. 2020; Ryan, et al. 2018; Fairchild, et al. 2016].

Rather than seeing sexual history taking as a means to an end, the GOALS framework considers the sexual history taking process as an intervention that can:

- Increase rates of routine HIV/STI screening;
- Increase rates of universal biomedical prevention and contraceptive education;
- Increase patients' motivation for and commitment to sexual health behavior; and
- Enhance the patient-care provider relationship, making it a lever for sexual health specifically and overall wellness.

The GOALS framework includes 5 steps:

1. **Give a preamble that emphasizes sexual health.** The healthcare provider briefly introduces the sexual history in a way that de-emphasizes risk, normalizes sexuality as part of routine healthcare, and opens the door for the patient's questions.
2. **Offer opt-out HIV/STI testing and information.** The healthcare provider tells the patient that they test everyone for HIV and STIs, normalizing both testing and HIV and STI concerns.
3. **Ask an open-ended question.** The healthcare provider starts the sexual history with an open-ended question that helps them identify the aspects of sexual health that are most important to the patient, while allowing them to hear (and then mirror) the language that the patient uses to describe their own body, partner(s), and sexual behaviors.
4. **Listen for relevant information and fill in the blanks.** The healthcare provider asks more pointed questions to elicit information that might be needed for clinical decision-making (e.g., 3-site versus genital-only testing), but these questions are restricted to specific, necessary information. For instance, if a patient has already disclosed that he is a gay man with more than 1 partner, there is no need to ask about the total number of partners or their HIV status to recommend STI/HIV testing and pre-exposure prophylaxis (PrEP) education.
5. **Suggest a course of action.** Consistent with opt-out testing, the healthcare provider offers all patients HIV testing, 3-site STI testing, PrEP education, and contraceptive counseling, unless any of this testing is specifically contraindicated by the sexual history. Rather than focusing on any risk behaviors the patient may be engaging in, this step focuses specifically on the benefits of engaging in prevention behaviors, such as exerting greater control over one's sex life and sexual health and decreasing anxiety about potential transmission.

Resources for implementation:

- Script, rationale, and goals: Box 1, below, provides a suggested script for each step in the **GOALS** framework, along with the specific rationale for that step and the goal it is designed to accomplish.
- GOALS Three-Part Video Series (NIH-funded BLUPrInt Project)
- Reimagining the Sexual History, GOALS Approach Evidence and Elements, and Taking Risk Out of the Pitch (AETC): A self-paced, interactive, online training
- The 5Ps model for sexual history-taking (CDC): Note that the GOALS framework is not necessarily designed to replace the 5Ps model (partners, practices, protection from STI, history of STI, prevention of pregnancy); instead, it provides a framework for identifying information related to the 5Ps that improves patient-care provider communication, reduces the likelihood of bias or missed opportunities, and enhances patients' motivation for prevention and sexual health behavior.

Box 1: GOALS Framework for the Sexual History		
Component	**Suggested Script**	**Rationale and Goal Accomplished**
Give a preamble that emphasizes sexual health.	*I'd like to talk with you for a couple of minutes about your **sexuality and sexual health**. I talk to all of my patients about sexual health, because it's such an **important part of overall health**. Some of my patients have **questions or concerns** about their sexual health, so I want to make sure I **understand what your questions or concerns might be and provide whatever information or other help you might need**.*	• Focuses on sexual health, not risk • Normalizes sexuality as part of health and healthcare • Opens the door for the patient's questions • Clearly states a desire to understand and help
Offer opt-out HIV/STI testing and information.	*First, I like to test all my patients for HIV and other sexually transmitted infections. Do you have any concerns about that?*	• Doesn't commit to specific tests, but does normalize testing • Sets up the idea that you will recommend some testing regardless of what the patient tells you • Opens the door for the patient to talk about HIV or STIs as a concern
Ask an open-ended question.	Pick **one** (or use an open-ended question that you prefer): • *Tell me about your sex life.* • *What would you say are your biggest sexual health questions or concerns?* *How is your current sex life similar or different from what you think of as your ideal sex life?*	• Puts the focus on the patient • Let's you hear what the patient thinks is most important first • Let's you hear the language the patient uses to talk about their body, partners, and sex
Listen for relevant information and probe to fill in the blanks.	• *Besides* [partner(s) already disclosed]*, tell me about any other sexual partners.* • *How do you protect yourself against HIV and STIs?* • *How do you prevent pregnancy (unless you are trying to have a child)?* *What would help you take (even) better care of your sexual health?*	• Makes no assumption about monogamy or the gender of partners • Avoids setting up a script for over-reporting condom use • Can be asked of patients regardless of gender • Increases motivation by asking the patient to identify strategies/ interventions
Suggest a course of action.	• *So, as I said before, I'd like to test you for* [describe tests indicated by sexual history conversation]. *I'd also like to give you information about PrEP/contraception/other referrals. I think it might be able to help you* [focus on benefit].	• Allows you to tailor STI testing to the patient so they don't feel targeted • Shows that you keep your word • Allows you to couch education or referral in terms of relevant benefits, tailored to the specific patient

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Supplement: Guideline Development and Recommendation Ratings

Table S1: Guideline Development: New York State Department of Health AIDS Institute Clinical Guidelines Program	
Developer	New York State Department of Health AIDS Institute (NYSDOH AI) Clinical Guidelines Program
Funding source	NYSDOH AI
Program manager	Clinical Guidelines Program, Johns Hopkins University School of Medicine, Division of Infectious Diseases. See Program Leadership and Staff.
Mission	To produce and disseminate evidence-based, state-of-the-art clinical practice guidelines that establish uniform standards of care for practitioners who provide prevention or treatment of HIV, viral hepatitis, other sexually transmitted infections, and substance use disorders for adults throughout New York State in the wide array of settings in which those services are delivered.
Expert committees	The NYSDOH AI Medical Director invites and appoints committees of clinical and public health experts from throughout New York State to ensure that the guidelines are practical, immediately applicable, and meet the needs of care providers and stakeholders in all major regions of New York State, all relevant clinical practice settings, key New York State agencies, and community service organizations.
Committee structure	• Leadership: AI-appointed chair, vice chair(s), chair emeritus, clinical specialist(s), JHU Guidelines Program Director, AI Medical Director, AI Clinical Consultant, AVAC community advisor • Contributing members • Guideline writing groups: Lead author, coauthors if applicable, and all committee leaders
Disclosure and management of conflicts of interest	• Annual disclosure of financial relationships with commercial entities for the 12 months prior and upcoming is required of all individuals who work with the guidelines program, and includes disclosure for partners or spouses and primary professional affiliation. • The NYSDOH AI assesses all reported financial relationships to determine the potential for undue influence on guideline recommendations and, when indicated, denies participation in the program or formulates a plan to manage potential conflicts. Disclosures are listed for each committee member.
Evidence collection and review	• Literature search and review strategy is defined by the guideline lead author based on the defined scope of a new guideline or update. • A comprehensive literature search and review is conducted for a new guideline or an extensive update using PubMed, other pertinent databases of peer-reviewed literature, and relevant conference abstracts to establish the evidence base for guideline recommendations. • A targeted search and review to identify recently published evidence is conducted for guidelines published within the previous 3 years. • Title, abstract, and article reviews are performed by the lead author. The JHU editorial team collates evidence and creates and maintains an evidence table for each guideline.
Recommendation development	• The lead author drafts recommendations to address the defined scope of the guideline based on available published data. • Writing group members review the draft recommendations and evidence and deliberate to revise, refine, and reach consensus on all recommendations. • When published data are not available, support for a recommendation may be based on the committee's expert opinion. • The writing group assigns a 2-part rating to each recommendation to indicate the strength of the recommendation and quality of the supporting evidence. The group reviews the evidence, deliberates, and may revise recommendations when required to reach consensus.

Table S1: Guideline Development: New York State Department of Health AIDS Institute Clinical Guidelines Program	
Review and approval process	• Following writing group approval, draft guidelines are reviewed by all contributors, program liaisons, and a volunteer reviewer from the AI Community Advisory Committee. • Recommendations must be approved by two-thirds of the full committee. If necessary to achieve consensus, the full committee is invited to deliberate, review the evidence, and revise recommendations. • Final approval by the committee chair and the NYSDOH AI Medical Director is required for publication.
External reviews	• External review of each guideline is invited at the developer's discretion. • External reviewers recognized for their experience and expertise review guidelines for accuracy, balance, clarity, and practicality and provide feedback.
Update process	• JHU editorial staff ensure that each guideline is reviewed and determined to be current upon the 3-year anniversary of publication; guidelines that provide clinical recommendations in rapidly changing areas of practice may be reviewed annually. Published literature is surveilled to identify new evidence that may prompt changes to existing recommendations or development of new recommendations. • If changes in the standard of care, newly published studies, new drug approval, new drug-related warning, or a public health emergency indicate the need for immediate change to published guidelines, committee leadership will make recommendations and immediate updates and will invite full committee review as indicated.

Table S2: Recommendation Ratings and Definitions		
Strength	**Quality of Evidence**	
A: Strong B: Moderate C: Optional	1	Based on published results of at least 1 randomized clinical trial with clinical outcomes or validated laboratory endpoints.
	*	Based on either a self-evident conclusion; conclusive, published, in vitro data; or well-established practice that cannot be tested because ethics would preclude a clinical trial.
	2	Based on published results of at least 1 well-designed, nonrandomized clinical trial or observational cohort study with long-term clinical outcomes.
	2†	Extrapolated from published results of well-designed studies (including nonrandomized clinical trials) conducted in populations other than those specifically addressed by a recommendation. The source(s) of the extrapolated evidence and the rationale for the extrapolation are provided in the guideline text. One example would be results of studies conducted predominantly in a subpopulation (e.g., one gender) that the committee determines to be generalizable to the population under consideration in the guideline.
	3	Based on committee expert opinion, with rationale provided in the guideline text.