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# How well are U.S. primary care providers assessing whether their male patients have male sex partners?

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#### ABSTRACT

Identifying patients at-risk for HIV infection, such as men who have sex with men (MSM), is an important step in providing HIV testing and prevention interventions. It is unknown how primary care providers (PCPs) assess MSM status and related HIV-risk factors. We analyzed data from a panel-derived web-based survey for healthcare providers conducted in 2014 to describe how PCPs in the U.S. determined their patients' MSM status. We calculated adjusted prevalence ratios (aPR) and 95% confidence intervals (CI) to describe PCP characteristics associated with systematically determining MSM status (i.e., PCP used "a patient-completed questionnaire" or "routine verbal review of sex history"). Among the 1008 PCPs, 56% determined MSM status by routine verbal review of sexual history; 41% by patient disclosure; 39% by questions driven by symptoms/history; 23% by using a patient-completed questionnaire, and 9% didn't determine MSM status. PCPs who systematically determined MSM status (n = 665; 66%) were more likely to be female (aPR = 1.16, CI = 1.06-1.26), to be affiliated with a teaching hospital (aPR = 1.15, CI = 1.06-1.25), to routinely screen all patients aged 13-64 for HIV (aPR = 1.29, CI = 1.18-1.41), and to estimate that 6% or more of their male patients are MSM (aPR = 1.14, CI = 1.01-1.30). The majority of PCPs assessed MSM status and HIV risk factors through routine verbal reviews of sexual history. Implementing a systematic approach to identify MSM status and assess risk may allow PCPs to identify more patients needing frequent HIV testing and other preventive services, while mitigating socio-cultural barriers to obtaining such information.

#### 1. Introduction

In 2006, the Centers for Disease Control and Prevention (CDC) recommended routine HIV screening in all healthcare settings for patients between the ages of 13 and 64, as well as repeat screening at least once a year for patients at high risk for HIV infection, a group that includes sexually active gay, bisexual, and other men who have sex with men (collectively referred to as MSM) (Branson et al., 2006). In April 2013, the United States Preventive Services Task Force (USPSTF) issued updated recommendations on routine testing for HIV (U.S. Preventive Services Task Force, 2013), which were largely consistent with the 2006 CDC HIV testing recommendations, and suggested that at least annual HIV testing for very high-risk groups, such as MSM, was a "reasonable approach".

Despite these recommendations, and several reports indicating the

acceptability of routine testing among the public (Christopoulos et al., 2012; Hack et al., 2013; Harmon et al., 2014; Jover-Diaz et al., 2012; Valenti et al., 2012), universal HIV testing has not been widely implemented in healthcare settings (Centers for Disease Control and Prevention, 2012a, 2013a; Hoover et al., 2013; McNaghten et al., 2013; Rizza et al., 2012), and many MSM are still not being screened frequently enough (Centers for Disease Control and Prevention, 2016). MSM who report being offered an HIV test by their doctor are more likely to disclose male-to-male sexual activity (Wall et al., 2010). Primary care providers (PCPs) who know their patients' sexual orientation are more likely to discuss sexual activity and risk behavior; however, many PCPs do not inquire about the sexual orientation of their patients (Petroll and Mosack, 2011). Given that sexual orientation or identity is not necessarily correlated with sexual behavior, it might be more accurate for PCPs to assess sexual behaviors among their patients.

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However, previous reports have indicated that healthcare providers feel uncomfortable discussing sexual behaviors in what they perceive to be low HIV prevalence settings, or cite a lack of time as a barrier to having these discussions with their patients during the office visit (Carter et al., 2014; Lanier et al., 2014; White et al., 2015). These barriers could potentially be overcome by the use of a systematic approach, such as a patient questionnaire, that does not require targeting specific clients or waiting for a patient to initiate disclosing their sexual orientation or HIV-associated risk factors to their physician. However, there are currently few tools to help clinicians assess their patients' sexual history and risk for HIV (Centers for Disease Control and Prevention, 2017; Knight and Jarrett, 2015; Lanier et al., 2014), and little is known about how widely they are used in health care settings, specifically in primary care settings in the United States. It is unknown what methods, if any, U.S. PCPs are using to assess their patient's MSM status.

The purpose of this analysis was: 1) to assess which methods U.S. PCPs use to determine which patients are MSM; 2) to characterize PCPs who identify MSM using a systematic approach; and 3) to describe which HIV risk factors PCPs assess among MSM patients.

#### 2. Methods

#### 2.1. Study sample

We analyzed data from DocStyles 2014, a web-based survey of U.S. healthcare providers (PCPs, pediatricians, obstetrician/gynecologists, nurse practitioners) conducted by Porter Novelli Public Services, a public relations firm that specializes in health and social marketing. The PCP sample was drawn from SERMO/WorldOne's Global Medical Panel, a marketing panel that in 2014 included over 270,000 physicians and over 1,000,000 medical professionals in the U.S. (Porter Novelli, 2014) The PCP sample included healthcare providers who identified as Family or General Practitioners, or as Internists. To reach a predetermined quota of 1000 PCPs, a random sample of 2512 health professionals, which included 1353 PCPs, was selected from the SERMO database to receive an invitation to participate in the web-based survey.

PCP respondents were screened to include only providers who worked in an individual, group, or hospital practice, and who actively saw patients in the U.S. for at least three years preceding the survey. The survey was conducted from June 18, 2014 to June 30, 2014. PCP respondents were paid an honorarium of \$69 for completing the survey. Completed survey responses were obtained from 1008 PCPs, representing a 74.5% response rate.

CDC obtained a license to access the results dataset of the DocStyles 2014 survey from Porter Novelli. The analysis was exempted from CDC institutional review board approval as no individual identifiers were included in the dataset provided to CDC.

#### 2.2. Measures

#### 2.2.1. Outcome variable

The main outcome variable for this study was whether PCPs used a systematic approach to assess MSM status among their patients, and was defined using the question: "How do you typically determine if a male patient has male sex partners? Select all that apply." PCPs using systematic methods were those who said they determined if their patient is MSM by either the use of a questionnaire completed by the patient, or through a routine verbal review of sexual history. PCPs not using systematic methods included those who indicated they do not assess MSM status, or those who say they could determine MSM status from questions driven by symptoms or history and/or from patient disclosure.

#### 2.2.2. Independent variables

Additional demographic and health-related covariates included age category (27–29, 30–39, 40–49, 50–59, and 60 or older); gender (male

or female); race/ethnicity (non-Hispanic white, non-Hispanic black/ African American, non-Hispanic Asian, non-Hispanic other/multiple race, and Hispanic); number of years practicing medicine (3-9, 10-19, 20 or more); whether PCP is affiliated with a teaching hospital (yes or no); main work setting (individual outpatient practice, group outpatient practice, or inpatient practice); use of electronic health records in practice (yes or no); average number of patient visits per week (< 100 or 100 or more); PCP-perceived financial situation of the majority of their patients (very poor/lower middle class, middle class, or affluent/ upper middle class); PCP-estimated proportion of patients who are MSM (< 1%, 1–5%, 6% or more, or "I don't know"); whether PCP routinely screens all patients 13-64 for HIV (ves or no): PCP beliefs about the most effective HIV prevention approach (risk-based HIV screening is the most effective approach, HIV screening for all persons age 13 to 64 is the most effective approach, or HIV screening is a public health concern and not an issue in my clinical practice); and if PCP has diagnosed patients with HIV in the past 12 months (yes or no).

To describe the HIV-risk behaviors assessed by PCPs among their MSM patients, PCPs were asked: "Which of the following characteristics do you assess among your male patients who have sex with men? Select all that apply." Response options included: patient's self-reported HIV status, frequency of HIV testing, number of male sex partners, new male sex partners since last HIV test, number of HIV-infected male sex partners, type of sex (e.g., receptive anal sex, insertive anal sex, oral sex, etc.), any recent history or current symptoms of sexually transmitted infections, recreational drug use, whether patient has sex without a condom, sex while using drugs or alcohol, and exchanged sex for money or drugs. Respondents could also indicate they did not assess any of the above.

#### 2.2.3. Statistical analysis

All analyses were conducted using SAS software (version 9.3, SAS Institute, Inc., Cary, NC). We performed bivariate analyses of demographic PCP characteristics, and practice-related factors associated with using a systematic method of identifying MSM, with the chi-square test. Crude prevalence ratios, based on Poisson regression models with a robust standard error with generalized estimating equation procedures, were used in bivariate analyses to test for overall differences in the use of systematic methods to identify MSM among the levels of independent study variables. We used a multivariable Poisson model to estimate adjusted prevalence ratios. The model included significant covariates as determined by chi-square tests, as well as race/ethnicity, regardless of the level of statistical significance because of its potential importance to the model. We used the backward elimination approach to remove covariates from the model with a *p*-value > 0.15. We present the unadjusted and adjusted prevalence ratios with 95% CI for the final model. For all analyses, we considered a p-value of 0.05 or less statistically significant.

#### 3. Results

#### 3.1. Methods for determining MSM status

When PCPs were asked how they assessed MSM status among their male patients (Fig. 1), more than half reported using "routine verbal review of sexual history" and less than a quarter reported "from a questionnaire completed by patient". Combining these two resulted in 665 PCPs (66%) reporting the use of at least one systematic method to identify MSM patients and 343 (34%) PCPs not using a systematic method at all, which included 90 (9%) PCPs who indicated they do not routinely assess MSM status among their patients.

#### 3.2. PCP demographics and practice characteristics

PCP demographics and practice characteristics are summarized in Table 1. The majority of PCP respondents were male (73%), with an

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