SEXUAL HEALTH CARE: MOTIVATORS AND BARRIERS

Issues Impacting Delivery of STD Services In Minnesota Publicly Funded Managed Care Programs

A Qualitative Research Study Among Minnesota Providers and Patients

A Component Of The
Minnesota Department of Human Services
2003 External Quality Review:
Sexually Transmitted Diseases

Conducted By:
Michaels Opinion Research, Inc.

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FORWARD

The Minnesota Department of Human Services (DHS) contracted with the Michigan Peer Review Organization (MPRO) to design and conduct an External Quality Review (EQR) study to assess the quality of care provided to publicly funded managed care program enrollees at risk of acquiring a sexually transmitted disease (STD). The EQR study evaluated the care provided to enrollees at risk for STDs in relation to prevailing national and local clinical practice guidelines.

Unlike most other diseases, there is a general reluctance by providers, parents and patients to openly discuss sexual health issues. To identify some of the key sexual health issues that stifle communications and the understanding of STDs, qualitative research techniques were used to explore and clarify the knowledge, attitudes and beliefs associated with the prevention, diagnosis and treatment of STDs. MPRO subcontracted with Michaels Opinion Research to conduct individual and focus group interviews exploring how gender roles, cultural taboos, misperceptions of risk and high risk behaviors influence sexual health.

The reader is encouraged to consider the information in both the qualitative and companion quantitative report entitled "Prevention, Screening and Treatment of STDs in Minnesota Publicly Funded Managed Care Programs" for a more complete understanding of the care and treatment provided by the health care delivery system.

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INTRODUCTION

In May 2003, the Minnesota Department of Health released data showing that the number of reported cases of sexually transmitted diseases (STDs) in the state had increased 19% between 2001 and 2002. The department's annual statistical summary revealed that for two reportable STDs—chlamydia and gonorrhea—rates had increased 21% and 13%, respectively, over the prior year.[1]

Some of this increase was attributed to improved compliance with state reporting requirements and to more frequent screening for chlamydia among women. In a disclaimer to the 2002 STD statistical summary, however, the Department of Health acknowledged that several factors, including the "level of screening, accuracy of diagnostic tests and compliance with case reporting," influence the accuracy of STD data.[1]

In fact, STDs are often called the "hidden epidemics" and the total number of cases is widely considered to be significantly higher than statistical data imply. As the U.S. Centers for Disease Control and Prevention (CDC) has observed:

> *STDs are difficult to track. Many people with these infections do not have symptoms and remain undiagnosed. Even diseases that are diagnosed are frequently not reported and counted.*[2]

Nevertheless, reported data on Minnesota STD rates, and their disproportionate impact on adolescents and young adults in urban communities of color, are consistent with national statistics compiled by the CDC.

- In Minnesota in 2002, adolescents and young adults aged 15 to 24 accounted for 70% of reported cases of chlamydia and 55% of reported cases of gonorrhea. Nationally, CDC data attribute 73% of chlamydia and 59% of gonorrhea cases to this age group.[1,3]

- Overall STD rates in the state are highest in the cities of Minneapolis and St. Paul. Chlamydia rates in 2002 were nearly 15 times higher among blacks than among whites in the state and gonorrhea rates were 39 times higher.[1]

The reduction of STD rates has proved to be a continuing national challenge. To address that challenge, public and private agencies in Minnesota and across the country have made concerted and ongoing efforts to increase access to routine health care, offer prevention and educational resources and develop clinical guidelines for prevention, screening and treatment of STDs.

In this environment, the Minnesota Department of Human Services (DHS), as purchaser of health care services for medical assistance populations, commissioned a 2003 External Quality Review study to assess the care provided to publicly funded managed care program enrollees at risk of acquiring, or diagnosed with, an STD.

Recognizing that medical record reviews and quantitative evaluations of provider compliance with clinical guidelines alone could not fully explain the range of issues that impact delivery of STD health care services and, ultimately, STD rates, DHS provided for a qualitative research component to the External Quality Review study.

Qualitative research is an excellent methodology for exploring problems that are not well understood. Individuals being interviewed are purposefully selected to represent a broad range of experiences. Interviews are structured discussions with open-ended questions that encourage rich descriptions and allow researchers to probe for greater detail and nuanced understanding of complex issues.

This report presents the findings of qualitative research designed to explore and clarify the emotional and attitudinal influences that providers and patients themselves perceive as motivators and barriers to STD prevention, diagnosis and treatment. Interviews were conducted with:

- Health care providers across Minnesota, specifically primary and specialty care physicians, nurse practitioners, nurses and clinical supervisors, who have direct contact with patients at facilities and clinics serving publicly funded managed care program enrollees.

- Patients utilizing these health care facilities who can provide insight into the barriers, motivators, attitudes and experiences impacting their access to and the success of STD education, prevention and screening efforts.

Through a series of in-depth, confidential interviews and focus group sessions with these providers and patients, the research examines:

- Factors that motivate patients to seek sexual health care.
- Barriers patients face in accessing care for STDs.
- How provider policies and practices influence patient education and screening for STDs.
- Barriers providers face in offering care for STDs.

The findings of this research are intended to contribute to the insight of health care professionals, clinicians, provider organizations and government policy makers who formulate and develop educational and screening programs designed to increase delivery of STD care and prevention services.

It is important to note that the findings of research such as this are highly qualitative by design and elicit information about factors that may influence or be indicative of attitudes or behavior. Because so few individuals participate, it cannot be assumed that the information revealed is either definitive or representative of the general population or subgroups within it.

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[1] Minnesota Department of Health, STD and HIV Section. Annual Summary: 2002 Minnesota Sexually Transmitted Disease Statistics. Available at: www.health.state.mn.us/divs/idepc/dtopics/stds/stdstats2002.html. Accessed December 1, 2003.

[2] Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention. Tracking the Hidden Epidemics 2000. Trends in STDs in the United States. Available at: www.cdc.gov/nchstp/od/news/RevBrochure1pdf.htm. Accessed December 1, 2003.

[3] Centers for Disease Control and Prevention, Division of Sexually Transmitted Diseases. 2002 Sexually Transmitted Disease Surveillance Report. Available at: www.cdc.gov/std/stats/toc2002.htm. Accessed December 1, 2003.

Methodology and Profile of Participants

To satisfy the research objectives, and to encourage a high degree of candor from participants, this study employed a series of confidential, in-depth interviews with:

Health Care Providers

Nineteen health care providers at clinics from different regions of the state that were identified by DHS as serving large segments of enrollees in Minnesota publicly funded managed care programs.

- Provider interviews were conducted by telephone from late May through mid June 2003. Providers were screened to ensure that all were health care professionals with direct patient interaction. Interviews lasted from 45 minutes to well over an hour.

- Providers interviewed were drawn from a cross-section of clinic types:

  — Community clinics
  — STD clinics
  — Family planning clinics
  — Specialty clinics
  — School-based clinics

- Interviews were conducted with a range of providers who have intimate contact with patients. The various professional and clinic positions held by these individuals included:

  — Medical director
  — Family practice physician
  — Primary care physician
  — Nurse practitioner
  — Physician assistant
  — Registered nurse
  — Certified nurse midwife
  — Clinic supervisor
  — Clinic manager
  — Program director

On-Site Clinic Interviews with Patients

Forty-one in-person interviews were conducted on-site with patients at 10 STD, community and specialty clinics in Minneapolis and St. Paul that serve populations of Minnesota publicly funded managed care program enrollees.

- At each clinic, interviews were conducted among a convenience sample of patients who were screened for a base level of sexual activity and to meet targeted demographic quotas.

- Interviews were conducted in two waves from August to October 2003. Each interview lasted approximately 45 minutes and, in some cases, were conducted with the assistance of on-site interpreters for Spanish-speaking patients.

- By demographic characteristics, these patient interviews included:

— Sex:	20 males 21 females
— Age:	25 18 to 29 year olds 16 30 to 45 year olds
— Race/ethnicity:	16 Blacks/African-Americans 9 Hispanics/Latinos 3 Asians 2 American Indians 11 Non-Hispanic Whites
— STD history:	16 had tested positive for an STD

Patient Focus Groups

A total of 31 participants in four two-hour focus group sessions with low-income men and women age 18 to 29 who are enrolled or would be likely to qualify for enrollment in one of Minnesota's publicly funded managed care programs.

- Focus group sessions, mixed by race/ethnicity and segregated by sex, were conducted at community centers in Minneapolis and St. Paul in October 2003.

- To increase the likelihood of gaining greater insight into issues that may be "barriers" to STD prevention, screening

and treatment, two groups (one with men and one with women) were conducted with individuals who said they tend to wait longer than they should to seek routine or non-emergency medical care.

- Two additional groups (one with men and one with women) were conducted with individuals indicating they typically do not delay seeking medical care when symptoms of illness occur.

- Focus group participants were recruited with the assistance and cooperation of organizations and individuals serving low-income communities and populations, including WIC distribution centers, food shelves, community centers, churches and congregate dining and through notices placed in local community newspapers.

- Participants were screened to provide a mix of ages and race/ethnicity in each group and to include those with a base level of sexual activity, who use or would use public health centers/clinics serving publicly funded managed care enrollees and who were of low-income status.

To maintain focus and insure consistency, provider and patient interviews and focus group sessions were conducted by only three senior female researchers following structured discussion guides that allowed discretion to probe for deeper more detailed information in the context of the interviews.

All patients participating in on-site interviews and focus groups were provided with cash honoraria, with the required notice of privacy practices and all executed informed consent to participate in research.

The research was designed and executed by Michaels Opinion Research, Inc., a public opinion research firm with expertise in STD- and HIV-related health care issues.

KEY FINDINGS

The research conducted with patients and providers reveals a number of important factors that may be influencing and encouraging testing for sexually-transmitted diseases (STDs) in Minnesota.

Through this series of in-depth interviews with over 90 individuals either providing services at or interacting with publicly funded health care facilities, we find that issues relating to access and cost are *not* significant barriers to low-income patients' decisions to be tested for STDs. In fact, regardless of their sex, race, ethnicity or socio-economic background, older teens and adults in the target age group (18 to 45), were aware of where they could get tested for STDs no matter what they could afford to pay.

According to the research:

- Publicly funded clinics located throughout the Twin Cities region are exceptionally well regarded by the patients who use them. Patients believe they are being treated with respect and receiving a high degree of professional care. They express strong loyalty to particular clinics, even those that are STD or specialty clinics.

- Generally, women are reported by providers to be the largest segment of the population base being treated at clinics, which directly contributes to far higher levels of routine STD testing among women. At the same time, however, routine testing of men occurs far less frequently because men are only apt to seek health care when they experience a problem or injury.

- In determining which clinic to use, men appear to be motivated by measures of location and convenience. Men are also highly sensitive to the patient base of the clinics they use, wishing to avoid facilities that mainly serve the needs of women and children.

- Clinic acceptance of patients with no health insurance, specific health plan affiliations or with sliding-fee payment options are all key factors that motivate patients to seek health care and sexual health care when needed. In fact, a delay in seeking sexual health care was usually attributed to a hope that the problem would go away rather than being based on concerns about paying for the cost of the visit.

- Overall, patients have a general awareness that "free" or "confidential" STD clinics exist in and around the Twin Cities region, though only a few could name or identify specific locations. Those who had received testing and treatment at an STD clinic nearly always felt they had been treated by professionals who understood the emotional turmoil of patients when they turn to an STD clinic. Indeed, the research suggests that use of STD clinics would probably increase if there was greater awareness of their philosophies, practices and locations. According to patients, the only downside to being tested at an STD clinic is that everyone in the waiting room "knows why you are there."

Perceptions of Risk and Condom Use

Perhaps the greatest challenge facing public health educators and providers is confronting the ongoing need to continually inform patients about the types of diseases that are transmitted through sexual and skin-to-skin contact *and* to reinforce the need for patients to use condoms when engaging in sexual relations.

- The prevailing attitude and behavior among patients is to use condoms only when there is a perceived need to protect against pregnancy or possible exposure to an STD. As expressed directly by patients, and even those who have received treatment for an STD, condoms are *not* generally used when sexual relations with a partner intensify and "trust" enters the relationship. Most patients say they use condoms for casual sexual encounters; some never use them because they do not like the way they feel.

- Though patients are strongly aware that the letters STD signify sexually-transmitted-diseases, their knowledge of specific diseases and treatments is shallow. In fact, one of the key barriers to patients' perceptions of personal risk for STDs is the lack of understanding that STDs do not always present symptoms *and* STDs can be transmitted by skin-to-skin contact and oral sex.

- Between men and women, decisions and practices relating to STD testing are very different: women are tested far more frequently during routine exams and following fear of exposure; men are most likely to be tested when concerned about a possible symptom or when they know there is a strong likelihood of exposure.

- Nearly always, women said they tested positive for an STD or sought out testing after learning that their boyfriends "were cheating on me." There were also very strong assumptions among women that they are being tested for a wide range of STD tests at the time of Pap smears (even if it is not discussed) and that if there was a problem, their providers would notify them.

- Even though patients perceive STD rates to be increasing and believe they are fairly well informed, they seemed genuinely alarmed when discussing five topics:

  — STDs are increasing, even in Minnesota
  — There are diseases out there they have never heard of
  — Not all STDs present symptoms
  — You can receive an STD through oral sex
  — You can receive an STD even when using condoms through skin-to-skin contact

The net effect of this information was usually to heighten perceptions that the risks for STDs are greater than they realized, and that they and, importantly, their partners should get tested more routinely. There was still, however, unwillingness among patients to agree that condoms needed to be used *always.*

Provider Practices

Provider practices at clinics frequented by publicly funded managed care patients generally appear to be highly pro-active in promoting STD testing. However, because men are not seeking routine care in the same way women regularly see health care providers, opportunities exist to intercept men for sexual health and STD counseling, even during episodic visits for other non-STD-related health care needs.

- Overall, providers are using a number of respected government and professional sources for developing STD risk assessment criteria for their patient bases. These guidelines and tools have reportedly prompted routine testing of adolescents and young adult women for chlamydia and gonorrhea, and those risk assessments have served to focus provider attention on the women and men to whom they offer screening.

- However, while the providers interviewed maintain that most patients are screened with STD risk assessment questions, some patients dispute that assertion saying it is done irregularly or not at all. Moreover, among those

patients that have been administered STD risk assessment questions, many say they are offended by the questions, usually withhold or soften the information they provide or have been judged with "raised eyebrows" when they responded truthfully. Another vocal group of patients see no point to such assessment tools if STD testing is routine or being sought specifically at an STD clinic.

- According to providers, changes in STD testing procedures – away from blood tests and toward urine or saliva tests – have made a significant impact on increasing patient agreement to be tested. Providers also say that in-office, rapid testing could have a measurable impact on increasing HIV testing. The most significant challenge relating to these less invasive, patient-friendly STD tests relates to reimbursement issues.

- Importantly, the providers interviewed see few barriers in their relationships with managed care organizations beyond the issues of reimbursement. However, there are strong concerns that billing for STD testing, especially when it involves youth, is not treated with the degree of confidentiality that is needed. Providers believe there should be a way to code bills and make them non-specific to protect a person's privacy.

Ongoing Education Efforts

- Patients and providers alike believe once someone becomes sexually-active, the abstinence message is not effective in promoting sexual health. And while patients will readily believe that condoms are the best practice for safe sex, they also admit they use them inconsistently.

- Many patients believe that there should be a greater effort to promote monogamy and testing among partners. While some men expressed skepticism, others say they were willing or have already made it a practice to get tested with their partners for STDs before beginning a relationship or discontinuing the use of condoms.

- Other recommendations from patients include greater discussion and dissemination of information between providers and patients. Patients, especially men, say their willingness to be tested for STDs increases when providers explain to them why it is important, what the procedures will be and what will be the course of treatment.

- Patients also believe brochures serve an important role, but they would like them available in examination rooms and to be presented in a manner that does not target minority groups in the population, be they people of color or gay.

CHAPTER ONE:
Patient Awareness of STDs, Perceptions of Risk and Protection Strategies

The series of interviews conducted with patients revealed a number of factors relating to STD awareness, safe sex and condom use, perceptions of risk and the benefits of STD testing that play complex roles in motivating and deterring sexual health care and STD testing.

Awareness of STDs

Among the 72 patients interviewed on-site at Minneapolis and St. Paul clinics, and in focus groups conducted in those cities, use of the initials "STD" was familiar terminology. Still, patient knowledge about specific STDs, symptoms and consequences was far less consistent. The research also suggests that strong associations between HIV/AIDS and STDs have both heightened awareness of sexual health issues among patients and influenced their perceptions of other STDs.

- ***There was near universal familiarity and understanding among the patients interviewed, both at clinics and in focus group discussions, that the letters "STD" refer to sexually transmitted diseases.***

I don't know what [STD] stands for, but it's something nobody needs.
—22-year-old Hispanic male

The only exceptions were among a few Latina women, who nonetheless were familiar with the Spanish "ETS" for *enfermedades de transmisión sexual*.

It means someone wasn't taking care of their health.
—43-year-old African-American female

While not all knew precisely what the letters stand for, they did know what "STD" implies. In fact, common use of "STD" was highlighted in one focus group session when a young women defined the term to general laughter: *If you're in a monogamous relationship and they tell you it's an STD, that means He Gave It To Me!*

The name STD does not scare you until you've had it.
—Female focus group participant

- ***The names of many STDs were easily listed by most patients, but other STDs, including the most prevalent, appear not to have risen into widespread consciousness.***

When asked to name any STDs they have heard or are aware of, patients would typically cite gonorrhea or "the clap," HIV/AIDS, herpes, chlamydia and syphilis. Mentioned far less frequently, and often never heard of, were trichomoniasis and HPV, though they were more likely to have heard of genital warts. A few patients also added hepatitis, "crabs" and scabies to their top-of-mind lists of STDs.

There's a bunch of them—AIDS, gonorrhea, crabs.
—18-year-old Hispanic male

Notably, awareness of chlamydia among patients interviewed in clinics was just as high among men as it was among women—about six-in-10 overall named chlamydia as an STD they had heard about. It was also the STD that women participating in the research were most apt to have directly experienced.

It is also important to note that although the number of interviews was limited and no definitive characterizations can be made about the broader population, young Latina women interviewed in clinic settings for this research consistently appeared to have only rudimentary information about STDs. When they were able to name any STD at all, it was likely to be HIV/AIDS or chlamydia.

- ***Trichomoniasis, one of the most common curable STDs in young sexually active women, was only mentioned as an STD by about one in three women interviewed.***

In high school, it hurt when I would pee. They said it was herpes . . . Later it was diagnosed as trich. But I lived with it for a year.
—Female focus group participant

Indeed, many young women had no awareness of trichomoniasis or whether they had ever been tested for the disease. Awareness of trichomoniasis among men was also very low though those who had previously tested positive for an STD had heard of "trich." One male in a focus group session related having read in a clinic pamphlet about: *the new diseases, like PID, trichomoniasis and epididymitis.*

Knowledge of STD Symptoms

Even though patients could name the most common STDs and recite some associated symptoms, they often exhibited a narrow understanding of STD symptoms, which clearly impacts their perceptions of risk.

If someone else had one, you see it. *You ask about it—lesions.*
—40-year-old African-American female

I don't know what [STDs don't have symptoms]. *I've heard about yeast infections that don't have symptoms.*
—43-year-old African-American male

I don't know. *I thought most [STDs] had symptoms.*
—23-year-old African-American female

Not any symptoms? Ever? *Maybe not right away. Eventually symptoms appear, don't they?*
—41-year-old African-American female

I heard symptoms might be mild. *Mild so you might not notice. Might not show up for years.*
—25-year-old white male

It's not true [that they have no symptoms]. People have it and don't know they have it, *but I think they are just in denial. They think it's just a yeast infection or the detergent.*
—27-year-old white female

- ***Even while feeling they are pretty "up on things," most revealed a very limited knowledge of STDs.***

The broad assumption is that STDs present obvious symptoms, such as sores, discharges, or burning sensations. Their profound lack of understanding that some STDs do not always exhibit symptoms nearly always came into sharp focus when discussing chlamydia, which is often without symptoms.

Revelations by several women in one focus group about having been diagnosed with asymptomatic STDs, for example, resulted in an excited outburst from another: *I thought I knew everything about STDs, but you all are coming up with all types of stories!*

And while in another session, men expressed general awareness that some STDs do not have symptoms, there were those who supposed that a lack of or delay in the onset of STD symptoms applied to women, not men. One young man restated a question about whether he knew that STDs may not have symptoms by saying: *You mean that females don't have symptoms?*

- ***Fully one in three minority men and women (African-Americans, Latinos and Asians) interviewed at Minneapolis and St. Paul clinics said they had never heard that STDs can be asymptomatic, and some others appeared unconvinced.***

This was in marked contrast to non-minority patients and, not surprisingly, to those who had tested positive for an STD, who were far more likely to say they were aware that some STDs may not exhibit symptoms. Patients who could name asymptomatic STDs were most apt to cite HIV/AIDS, chlamydia and gonorrhea, but just as often, patients were unable to name any STDs without symptoms.

Regardless of race or ethnicity, however, there were also those who seemed unwilling to acknowledge that STDs could be totally asymptomatic. Rather, they reported having heard that it was possible for STDs to have "latent" symptoms that might not appear "until it's too late."

- ***Learning or being reminded that some STDs have no symptoms heightened concern about the risks of contracting an STD.***

Learning or being reminded that some STDs may not present obvious symptoms clearly troubled some patients and focus group participants. In response, many expressed an anxious desire to learn more about the symptoms they should be looking for and the prevalence of STDs in general.

I would worry that I might have it in my body *and not know until it's too late.*
—32-year-old Hispanic female

Most patients became particularly worried that they "might not know" they had an STD, a concern that encompassed feelings ranging from guilt about spreading a disease to others, to fear that their bodies were being irreparably damaged, to anxiety over "being sick and dying." For a few, awareness that STDs can be asymptomatic encouraged them to want more frequent STD testing. But others said this knowledge now motivated them "to be more careful" because they "wouldn't know" whether a partner had an STD.

It's scary. *You might never know, but you'd be walking around with it the whole time.*
—18-year-old African-American male

[With no symptoms], it makes me want to be way more careful *and not have so many partners.*
—22-year-old Hispanic male

Although it is impossible to predict the degree to which actual behavior might be altered in moments of passion, learning that STDs may not have discernible symptoms increased the sense of risk for many, as it did for one 39-year-old African-American male: *Just 'cause she looks clean on the outside, you don't know about the inside. You're taking a risk then.*

- ***Men and women expressed significantly different concerns about, or awareness of, the possible complications arising from STDs.***

Women most often mentioned "infertility" as a health consequence of contracting an STD. Men, sometimes hard-pressed to think of any consequences of STDs beyond a concern that their "penis might fall off," were far more likely to refer to "death," incurability or simply "feeling sick." Very few men or women, however, cited other physical complications of STDs, like increased risks of cervical cancer or of contracting HIV. A few did say that a *positive* outcome of having an STD is encouraging more responsible behavior, but this was occasionally countered by those who admitted they were still having unprotected sex, even after having been treated for an STD.

I see this commercial for Valtrex for genital herpes. So that must mean that a lot of people have genital herpes. *So, slow down, because a lot of things I can't get rid of.*
—Male focus group participant

Some [STDs] are just a virus that's there in your body. It's not going to do anything. *It's not going to turn into anything. It's just there and you're a carrier. And there's other things that you can die from. Some things that will give you bumps, some things that will give you nasty sores.*
—Female focus group participant

It's bad. It spreads to other people...*You're not normal and you don't feel good. You would be scared.*
—18-year-old Asian male

That's what I'm afraid of—that you can't have sex until it's cured. *Is it curable or not?*
—41-year-old African-American female

You can't get rid of herpes. Some of them can kill you.
—18-year-old African-American male

If I had it, it would mess me up mentally knowing I can't do anything anymore. *If it's HIV, there's a chance your life could be short.*
—26-year-old African-American male

- ***Men and women also believed a major negative of contracting an STD is the inability to have sex, potentially forever, and rejection from current and potential partners.***

The psychological or social consequences of STDs, including mentions of depression, lowered self-esteem and decreased opportunities for sexual activity, were more often raised by men and women in their 30s and early 40s than by younger patients. But among younger patients, one-in-three saw transmission to sexual partners or to babies at birth as a key complication of STDs. *You can pass it on*, an 18-year-old Latino male said, *give it to other people. That's the worst [consequence]. Creating a circle.*

- ***Strong associations with HIV/AIDS could be seen in patients' views of the consequences of having an STD. Moreover, while most envision serious problems resulting from STDs, few were able to name specific complications.***

Many patients were clearly distressed by what they quickly identified as the potential consequences of STDs—"death" was the word they most frequently used, followed by general "poor health" and "incurable." Although subsequent findings suggest that most patients do not feel they have put themselves at risk for contracting either HIV/AIDS or herpes, fear of the consequences of those diseases were plainly at the forefront of their anxiety. As one 18-year-old Asian male commented, admitting some uncertainty over the exact meaning of every letter in STD: *It's AIDS or a transmitted disease that kills you from having unprotected sex.*

Perceptions of Risk

In addition to condom use, some patients added that they could lower their risks of acquiring an STD by "not having multiple partners" or "getting tested." Some suggested that monogamy, "communication" and "honesty" were important and acknowledged that if they were unable to discuss with their partners concerns about protection and risk, including their histories of STDs and testing, they probably should not be having sex with them.

I know it's out there. It doesn't make me think any different. *I might want to be a little bit more careful.*
—Male focus group participant

[STDs are bigger] in the U.S. because there's more freedom here. *[In Minnesota] it's less than in the U.S.*
—23-year-old white female

You don't hear a lot about it, but I just think there may be a lot of STDs.
—19-year-old Hispanic female

I've heard and read things. The 612 area has a high STD rate*—the highest in the nation, I've heard.*
—18-year-old African-American male

In 55411 there's a lot more cases *of chlamydia and gonorrhea in girls 11 to 24. Remind me to move.*
—Female focus group participants

However, their appraisals of the incidence of STDs in their communities, their assessments of why some people are prone to acquire STDs and their attitudes toward condom use and sexual behaviors combine to suggest a significantly diminished sense of personal risk particularly common to sexually active adolescents and young adults.

- ***Nearly all believed that the rates of STDs are high and escalating in the U.S., Minnesota and the Twin Cities as well.***

Still, some patients supposed that STD rates are generally higher in places like "Africa" or in "Third World countries," and even if the risks are high in the U.S., they are probably less so in Minnesota.

Among those believing that STD rates in Minnesota and the Twin Cities area have increased, media reports and rumors about the local incidence of HIV/AIDS appear to be key sources.

- ***With surprising frequency in both personal interviews and in focus group sessions, patients commented that they had heard about exceptionally high rates of HIV/AIDS in the North Side neighborhood of Minneapolis, Area Code 612 or Zip Code 55411.***

This information was attributed to news reports, talk show discussions on black radio and unnamed "studies" they had read about. One group of men agreed with the assertion that "one out of every 10 persons on the North Side has AIDS," which they blamed on "drug use," "people being careless" and "dirty women"—"hood rats" sitting on cars looking for sex. One patient noted that it was not race that made people in this area more likely to get an STD; it was a class issue. He noted that: *It's a level, where you are at.*

As a result, one man who had also heard of the area's reputation declared that "you don't want to be freaking everything that moves, especially on the North Side." Conversely, a group of women said they were prompted to "be leery of men from North Minneapolis."

Other patients, albeit a small number, ascribed STD rates in Minnesota and the Twin Cities to "more teens having sex," "people having multiple partners," "ignorance," inconsistent condom use, immigration and greater "diversity," as well as lack of family structure and declining "morals."

I use them [condoms]. I make it a rule. *After hearing about the epidemic on the North Side, and they travel to the South Side. There's a big epidemic of AIDS—more than anywhere in Minnesota, and that's very scary. The women are hot, and you can get what you want if you want AIDS. It's best to use two or three condoms.*

—43-year-old African-American male

Women can get [STDs] faster than men. *They've got other things happening in the body. I talk to more women who say they got it.*

—18-year-old African-American male

Men and women are equally likely. *They're just human. Men can sleep with a lot of women. Women do the same.*

—26-year-old Native American female

Like, I caught it from her and she caught it from somebody else *by doing the same thing—not wearing a condom. It's a mistake for both.*

—Male focus group participant

These assertions, however, also provided many with an escape from their own perceptions of self risk for contracting an STD. Sometimes noting that "things are not so bad in my neighborhood," they sought to distance themselves from or, at minimum, exercise extreme caution with those in "other" communities.

Additionally, a few white patients felt they were at less risk because they are white. One 26-year-old white male who had tested positive for an STD said, for example: *I knew there were risks, what I was in for, but as a straight Caucasian, I believed the odds were stacked in my favor*.

- ***Patients expressed divided views over whether men or women are equally susceptible to acquiring an STD. They were, however, almost unanimous in calling "unprotected sex" the main reason people contract STDs.***

Overall, patients hold different attitudes regarding who they believe, men, women or both equally, are more prone to contract an STD. Those believing that men are at greater risk for contracting an STD were apt to attribute it to greater sexual promiscuity among men. When women were perceived to be more susceptible to infection, it was usually based on the belief that their physical anatomy, a vagina, presented a better condition for bacterial or viral infections. Yet, many patients interviewed took the position articulated by one 22-year-old African-American woman: *It takes men and women to sleep together and both have multiple partners equally*.

While there was wide agreement that "anyone" can get an STD, patients tended to view those at greater risk as people who are "careless or ignorant," have weak immune systems, are "lower-class" or "younger."

By overwhelming sentiment, however, patients declared that people contract STDs because they have unprotected sex. Far fewer mentioned other risk behaviors like multiple partners, one-night stands, patronizing "hookers" or sharing needles.

- ***Awareness of risks for contracting STDs through oral sex was very uneven among the patients interviewed. Few knew with confidence of the possibility of transmitting or acquiring certain STDs orally.***

Most men considered oral sex "safe" and one even noted that he only engaged in oral sex with women, believing it was the best way to avoid diseases and pregnancy. But others, both men and women, said they had heard rumors or were not certain, whether one could contract an STD through oral sex. Usually, herpes was the disease most likely to be mentioned as one that could be transmitted orally.

I might have heard something about [oral sex risk]. I wish I had more information. *I think there's maybe a 50-50 chance of getting something. I don't know if you can get AIDS through that.*
—24-year-old Hispanic female

I didn't know until college you could get STDs orally. *I knew they were out there, but not that you can get them in your mouth.*
—Female focus group participant

Nevertheless, during the focus groups, it became very evident that patients were not well informed about the risks associated with oral sex as they reacted with deep concern to information provided in an STD prevention education brochure. In all sessions where the brochures were presented, patients became alarmed when reading to each other the relative ease by which herpes, syphilis, Hepatitis A and, especially, gonorrhea could be transmitted orally.

Women who had heard about the risks of oral sex were often unsure about "how to protect yourself." "It's not stressed as much as genital," one said. A few others confessed that they had rejected use of condoms for oral sex because of the taste or feel, but "were not down with using dental dams."

- ***The research further suggests that some patients hold false perceptions of how some STDs are transmitted and that heightening awareness of contracting STDs through behaviors other than sexual intercourse can be deeply disheartening information.***

I thought I had covered my bases by getting tested. *But I had HPV and it didn't show up in the test. I couldn't tell you when and how I contracted it. It was devastating.*
—22-year-old African-American female

I know I don't know enough about STDs. *I suppose there are lots of ways to get AIDS besides sex.*
—22-year-old Hispanic male

In both personal interviews and focus group sessions, many patients openly discussed their lack of awareness, knowledge and understanding about how some STDs can be transmitted and some revealed erroneous perceptions. For example, without any challenge from others about its accuracy, one woman claimed in a focus group that: *My doctor told me you can get chlamydia from a toilet seat or warts from sitting on the edge of a swimming pool.*

Importantly, there was a detectable sense of unease about effectiveness of condom use when in one group session a woman talked about being diagnosed with genital warts when "I hadn't even had sex yet," that she had contracted it through skin-to-skin contact. Indeed, all discussions about skin-to-skin transmission

and the presence of other not commonly known diseases like HPV and trichomoniasis caused a certain air of distress among those being interviewed.

Safe Sex and Condom Use

The twin STD-prevention messages of condom-use and abstinence have clearly penetrated into the consciousness of the sexually active men and women interviewed. Like a mantra, abstinence and condoms were quickly cited by patients during these interviews as the most effective ways to reduce the risk of acquiring an STD. Rising STD rates in Minnesota and across the country, however, indicate that the impact of these messages on actual behavior is often neither persuasive nor pervasive. Condom use, as patients easily admitted, is inconsistent.

Use protection—condoms, not just birth control pills. *Know your partner and where they have been. Before having sex, get a flashlight and say, 'Baby, let me look.'*
—43-year-old African-American female

- ***Abstinence as a means of avoiding STDs was seen as "not realistic" by both patients and providers.***

In interviews and focus groups with patients, a rote recital of the abstinence message was frequently accompanied by a skeptical roll of the eyes. Some providers in these Minnesota clinics, in fact, called abstinence education programs a "waste of valuable resources." Patients cited sexual drive and fear of losing a relationship as impediments to abstinence as a practical method of avoiding STDs. Some young women said, though, that while abstinence did not make sense to them, they did believe that "waiting until you know someone better" was responsible behavior.

- ***Almost all patients instantly called condoms the best form of protection against STDs. But some assume condoms will protect them from all STDs and do not understand the risks they may still face from skin-to-skin contact.***

I became aware of symptoms—warts in my genital area. *You can get HPV wearing a condom. Condoms are not 100 percent effective against diseases.*
—26-year-old white male

Patients, including non-English speaking Latinas, understood both the disease prevention and birth control benefits of condoms. Few, however, were aware that some STDs could be transmitted despite condom use. When this fact was shared openly in focus groups, the group reaction was usually one of alarm. And in private one-on-one interviews, one male patient said he only learned that condoms did not protect him after having tested positive for HPV.

With increasing numbers of young women now using alternative methods of birth control, including Depo-Provera, which was administered in many of the clinics where these patients were interviewed, condom use was often associated primarily with disease prevention. When diseases are not feared, however, reliance on alternative birth control methods diminishes condom use.

Women are right. . . You really have to think about the condoms. *She's got her clothes off, it's the last thing you're thinking of. The condoms better be right there.*
—Male focus group participant

While many patients said they try to use condoms "most of the time," and often viewed condoms as mandatory with "one night stands" and at the beginning of relationships, they noted a number of barriers to consistent condom use. They also cited "the heat of the moment" as a reason for not practicing safe sex. For some, not having a condom available appeared to have little impact on decisions to proceed with sex or not. They had sex, then worried about the potential consequences later.

- ***Many patients explained that while they use condoms initially in sexual relationships, once they "know the person" and begin having relations on a regular basis, they inevitably discontinue condom use.***

I always put [a condom] on. Sometimes I haven't put it on, *but it's my girlfriend and she knows me and I know her.*
—18-year-old African-American male

Among the men and women interviewed many said they use condoms only intermittently, either because they were "in relationships," "trusted" their partners or simply because they preferred the "feel" of sex without condoms and felt minimally at risk. And even among those who had experienced an STD, most admitted not using condoms consistently for these reasons.

According to patients, condoms are not used on a consistent basis in "monogamous" relationships; mainly to prevent pregnancy and rarely to protect against infection from an STD. They said that once you believe you are moving into longer-term relationships, trusting the other person begins to complicate the issue of condom use.

I don't have a problem with using condoms—either male or female. *I don't have a problem saying it's this way or no way. It means the chance of living or dying.*
—27-year-old white female

Some said they will ask new partners questions to assess their risks for STDs, such as the number of partners they have had or whether they have ever been tested for an STD. Based on their partners' reactions to questions, regardless of whether it is in anger or openness, decisions will be made about continuing or stopping the use of condoms. Nevertheless, while most acknowledged that partners may be harboring an STD without knowing it, few actually applied or considered this understanding when having unprotected sex with someone they "trust."

Although infrequently, a few women were emphatic about insisting on using condoms every time. In contrast, others shrugged and reported that they did not practice safe sex because their boyfriends did not like condoms.

- ***Both men and women reported to dislike using condoms because the "feel" is not as good as unprotected sex. Some also reported a belief that they were latex intolerant.***

I'd rather not use condoms. I think I have latex intolerance. *If I had a partner that was new and we had not been screened, I'd make them use it. If it was a partner I'm serious about, and we didn't want to use condoms, we'd go for STD screening. But now I'm more mature. When I was young, I didn't think this way.*

—35-year-old white female

Most men and women said they do not like using condoms because it interrupts "the heat of the moment" and reduces sexual sensation. A number of men, in fact, pointedly said they refuse to use condoms and some would end relationships if girlfriends insisted on long-term or consistent use of condoms. In turn, women also reported being pressured by partners to stop using condoms, especially if they were using another method of birth control. And women, themselves, admitted not wanting to use condoms, "if I don't have to."

I don't use them [condoms]. I don't like them. *If someone requires that I use them, there's no need to be having sex with them. It's all about trust.*

—43-year-old African-American male

- ***Condom quality also appears to have an impact on consistent use.***

Although condoms are free at the clinics, and a number of patients interviewed had picked up some while there, the perception is that clinic condoms are not high-quality, but "cheap" condoms. Clinic condoms were described as "those thick white ones" that may not cost anything, but reduce feeling, sexual sensitivity and pleasure.

A few women said they preferred using the female condom, but the overwhelming experience among both men and women was of no exposure to female condoms. Among those aware of or experienced in using female condoms, they were perceived as providing greater protection and physical sensitivity. Women who used them also liked assuming the responsibility for using protection and avoiding having their partners balk at using condoms.

People just don't care at the moment. *If they don't get an STD, they might get a kid. They think it can't happen to them. They don't get it. They don't take it seriously. At one time in my life, I didn't either. . . Alcohol has a lot to do with it. You're not yourself when you drink. You don't care.*

—22-year-old Latino male

- ***A few patients mentioned "not caring," feeling like "nothing's going to happen to me," and sometimes cited drugs and alcohol as contributing factors to risky sexual behavior.***

Many patients exhibited a kind of "temporal myopia," of thinking only in the moment, that was frequently intensified by alcohol and drugs. They often saw themselves as young and

healthy and detached from concern about risk. But in saying "they don't care," it was apparent they often meant that they do not care "right now." In the environment in which many of these patients socialize, people easily "hook up after bars and clubs." As one young Hispanic man said: *When people drink, they don't care. They just say, I like this person.*

People are not educated enough. *They have an 'it's not going to happen to me' attitude. I don't think Minnesota is any different. In general people don't take it seriously, especially teenagers. They think they are invincible, they don't need to protect themselves. They think, that person looks okay to me.*

—35-year-old white female

Both men and women admitted that alcohol and drugs, as well as the pulsating environment of the club scene, contribute to the high incidence of unplanned sexual relations with men or women who are little known or completely unknown to them.

The older teens and young adults interviewed also exhibited a strong belief that because of their age and general good health they do not easily perceive risks at times when they should.

- ***Patients frequently said they assess their partners visually and by reputation.***

I heard rumors about her sleeping with other guys and getting lined-up . . . *She said she was tested twice already and she didn't have it, but I didn't do nothing with her.*

—18-year-old Asian male

Men and women often determined whether to have sex, and particularly unprotected sex, with someone after thinking "he looks clean," or believing their partners have had a reasonably limited sexual history: "She's not one of those girls – like a gang-banger." When pressed, they said they understood that personal hygiene does not correspond to a lack of sexual disease, but, nevertheless, still tended to make judgments such as "He's nice" when opting not to use condoms.

CHAPTER TWO:
Seeking Sexual Health Care and STD Testing

Within the age group targeted for this qualitative research (18 to 45) women are far more likely to seek out routine health care than are men. In testimony before the Congressional Subcommittee on Health in June 2001, one physician said quite simply that "men are notorious for their avoidance of health care," and he cited research indicating that one in four men would "wait as long as possible before seeking attention for a serious medical problem."[1]

Most of us guys just sweat it out. *It's got to be something serious.*
—Male focus group participant

The findings of interviews conducted with providers across Minnesota and with patients in Minneapolis and St. Paul consistently reflected this behavior. Health care providers in Minnesota clinics confirmed that, except in school-based clinics, they tend to see a patient base that is predominantly female.

- ***Women interviewed at clinics were more likely than men to have come for a wide variety of health care issues. Almost all women said they get routine annual physicals, including gynecological exams.***

Nearly all of the women interviewed at clinics said they had been at the clinic before, with three in four saying they tend to have routine checkups and see health care providers on a regular basis, as well as when necessary for other problems. The availability and affordability of Depo-Provera also brought some women into clinics regularly.

The women interviewed were at primary care clinics for a variety of medical services including annual exams, blood pressure or diabetes follow-up, care for various ailments, gynecological exams or STD testing and follow-up.

[1] David H. Gremillion, MD. The University of North Carolina School of Medicine at Chapel Hill. Prepared witness testimony on HR632 before the House Subcommittee on Health. June 27, 2001.

- ***In contrast, the majority of men said they were at the clinic for the first time and stated they were likely to seek health care only when they experience a health problem or injury.***

In fact, most men interviewed at community clinics said they were there for non-urgent medical problems, like a sprained ankle or shoulder injury. Surprisingly, if the community clinic was close to their homes, nearly as many said they had been "just walking by" and wanted to "check it out." A few young men stopped in to pick up free condoms.

I go to the clinic with my girlfriend. *She doesn't like going alone, so I get checked up, just for the hell of it.*
—Male focus group participant

While a few men had come to community clinics specifically for STD testing or test results, almost none were there for routine check-ups. The attitudes expressed by one man in a focus group session was typical of these men's position: *I'm healthy. What could be wrong? If it looks serious, I'll do something about it, but only if it gets worse.*

Choosing A Clinic

For most patients, the critical consideration in choosing a clinic was determining whether or not the providers "care" about and respect patients. For non-English speaking patients, the availability of a translator was a significant issue and it appeared from interviews with these patients that clinics have responded well, and professionally, to this need.

Patients rarely had negative comments about their experiences at the clinics in which they were interviewed. That is not to say, however, that all of their clinic encounters were positive or that a few did not express occasional criticisms about cleanliness, waiting times or the difficulty of making appointments.

- ***In selecting one clinic over another, men were often motivated by convenience, but their willingness to return to a particular clinic was an emotional reaction to the manner in which they were initially treated. Women were more likely to seek and value an established relationship with "their" clinic.***

I pick a hospital or clinic near my work*—just for a tune up, to make sure everything's working okay.*
—Male focus group participant

Word-of-mouth was the primary reason many patients had initially chosen to come to a specific clinic, particularly the STD clinics. Patients often said that "a friend told me to come here" or "I heard about it somewhere."

Women were more likely to have relied on recommendations by family members or friends and they had often been using the

I've been going to this clinic for 12 years. *My mom found it for me.*
—23-year-old African-American female

This clinic was close when I lived here. *I moved, but now I trust this clinic.*
—40-year-old African-American female

I'm comfortable with my clinic, but would be wary of going anyplace else. *The way people treat you makes you want to come back. Feeling that they care. Facts are straight up.*
—Male focus group participant

same clinic for years. Several women said they had visited a number of clinics before choosing the one at which they felt most comfortable. Women sought relationships with clinics because they expected to come in at least once a year for routine check-ups and gynecological exams. A few remarked that even after moving, they continued to travel to "their" clinic in order to maintain the relationships they had developed with providers and staff.

Most said, however, that even though they came to the same clinic, they often did not see the same doctor every time. While they did not typically form a relationship with a particular provider, they felt an affinity for and relationship with the "kind of doctors" at the clinic.

The desire to maintain relationships with providers, however, was emphasized by patients who noted with disappointment, but understanding, the frequent turnover of physicians who "are in training" at some clinics.

- ***Clinic acceptance of insurance providers or the willingness to make payment arrangements were also very important considerations.***

I didn't know about some of these clinics. *They should make a list, and show the hours, too.*
—Male focus group participant

For most of those interviewed, the cost of receiving medical care was not a barrier to seeking medical attention for either routine or non-urgent care. In fact, patients and focus group participants repeatedly mentioned their reliance on clinics that "let you pay what you can" or "on a sliding scale." Most seemed aware that free clinics were available if needed; though awareness of specific free/low cost STD clinics was not as pervasive. Some did say, however, that they needed more readily accessible information about different clinic locations and their hours of operation.

- ***Patients sometimes made judgments about using or returning to clinics based on perceptions of clinic cleanliness, how comfortable they feel among other patients or how long they will have to wait to see a physician.***

This is a very nice clinic. Looks okay for me. *People are not waiting a long time. No babies screaming. No mothers.*
—18-year-old African-American male

Physical appearance was often the first clue patients used to determine the level of a clinic's professionalism. Some commented negatively about clinics they had been to, and now avoided, because they looked "dirty," were "not up to date" or even had overflowing "garbage that had not been taken out."

Men frequently indicated not feeling comfortable in family planning clinics, or during certain hours at community clinics, where they had to wait "with a bunch of screaming babies." One provider at a family planning clinic, for example, confirmed that: *high school guys don't come to our clinic. They see it as a women's place.*

***[Those clinics] in 'a house.' It's not what you expect** for a place where you're going for [medical services].*
—Male focus group participant

It is important to note again that few patients had any complaints about the clinics in which they were interviewed, generally believing they were treated with respect regardless of their race, ethnic background or socioeconomic status. But a few related criticisms about waiting times, either on hold trying to schedule an appointment or by the perceived delay obtaining an appointment within a short time. In this regard, STD clinics such as the Red Door were cited as extremely responsive to patients because, as walk-in clinics, "you can get an appointment the same day." Longer waits for appointments at most clinics were typical, patients said, which they found less-than-acceptable when they want to be checked immediately.

- ***For some patients, the most negative aspect of STD clinics is the waiting room, not the treatment.***

***A lot of people don't want to be seen going back and forth there.** It's an STD clinic. I made an appointment to go there and someone said to me, 'What are you going there for? You must have something.' So I automatically didn't want to go.*
—41-year-old African American female

Although confidentiality is considered important and stressed to patients using STD clinics, patients felt a certain irony exists with everyone in the waiting rooms being reasonably certain why each of them is at that clinic. A few patients, in fact, had seen someone they knew in an STD clinic waiting room and felt awkward. Some said they looked for clinics that were outside of their neighborhood so they would not be likely to meet anyone they knew.

Seeking Sexual Health Care and STD Testing

Being tested means you can keep having sex without being concerned *either for yourself or your partner.*
—22-year-old white female

In describing the advantages they see to STD testing, the vast majority of patients most often described a range of emotional, rather than physical, benefits, including peace of mind and the knowledge that they were "clean." They also cited the ability to reassure and protect their partners, a confirmation that they had made and could continue to make the right choices, a boost for their self-confidence and a strengthening of their relationships.

[The benefit of being tested] is knowing for sure, like right now. *Being able to tell a potential partner when you're discussing it.*
—38-year-old white male

While men said that they *should* be tested if they had engaged in risky behavior, their actions suggest they usually seek testing only if they have symptoms. Women, however, appeared far more motivated by worry about possible exposure, while several said they have made appointments for STD testing on a proactive basis. Overall, the majority of men and women interviewed had been tested for STDs at one time and about one-in-three had tested positive.

Far less frequently, patients also said that by being tested for STDs they could get treatment, if necessary, and "catch any problems early," before there was irreversible damage. A very few patients could not describe *any* benefit to being tested for STDs, citing a fear of AIDS and that they "didn't want to get scared" by even considering STD testing.

Knowledge is power. *If I know [I have an STD], I can make good choices. Abstinence, if necessary, using condoms or more frequent visits [to the clinic].*
—41-year-old white female

Still, any sense of urgency patients communicated about the need to seek sexual health care, specifically STD testing, was strongly symptom driven, especially for men. Yet, when discussing the circumstances that would prompt them to seek STD testing or sexual health care, patients, particularly women, were just as likely to talk about anxiety over possible exposure to an STD as they were to cite symptoms of an STD.

I'd get tested if I was displaying some symptoms, *any possible symptoms since I don't know what they might be. Or if I had contact with someone I later found out might be at high risk or had an STD.*
—38-year-old white male

Patients in personal interviews and focus groups typically said they would not delay going to a clinic if they had symptoms of an STD or felt that "something wasn't right."

- ***An archetypal "burning" or "hurting" on urination led the list of symptoms patients associate with signs of an STD infection and the need to "get checked out."***

I would know if it didn't feel right down there. *Everybody knows their body. If you're not using protection, you worry if something is not right.*
—22-year-old Hispanic male

Most men and women also identified discharges, odors, staining or "pus," as well as physical marks like bumps, lumps or "if my penis looked weird" as symptoms that would prompt them to seek care. But they also expressed uncertainty over whether they were aware of the full range of possible STD indicators that should cause them concern. Many, for instance, would preface

lists of STD symptoms by commenting that they would "just know something is wrong." As one 18-year-old Latino male insisted: *I know my body very good. If something was going on with my body, I would go get that checked up.*

Men typically said that if they had symptoms of an STD, they would go to a clinic "right away" and nothing would derail them. Yet other men said they would second-guess themselves, trying to decide if symptoms are imaginary or hoping they will go away on their own. They did not want to visit a clinic and get tested if it was a false alarm.

You think your symptoms aren't that bad. You just dismiss them, say it's nothing. *I waited a week before I came in here [to be tested]. I was unsure. It plagues me. I need to get it out of the way.*

—25-year-old white male

You're scared to know if you have something. *Maybe it will just go away, or it's just a mind thing.*

—22-year-old Hispanic male

Another reason some said they had avoided being tested was fear of the possibility they *did* have an STD and what a diagnosis would set in motion. Some also said they were embarrassed. A 36-year-old white male said: *I denied it until it hurt so bad I didn't have a choice. When you tie sex to a disease, it's embarrassing. It's hard to go to a doctor and admit something like that. It shouldn't be that way. More education would help.*

- ***For women, symptoms of an STD would also motivate a clinic appointment, but most said they know or assume they are already being regularly tested for STDs.***

Importantly, most of the women interviewed knew or assumed they were being routinely tested for STDs at the time of their annual gynecological exams. A 26-year-old American Indian woman, for example, said she would only seek out STD testing if she: *was having too many partners with no protection or had something on my lip from kissing, if my stomach hurt, a discharge. But every six months with the Pap smear, they do it anyway.*

- ***More concretely, some patients said they would be or had been motivated to ask for STD testing, not by symptoms, but because they felt at risk.***

Women were far more likely to say that they get tested routinely, even without symptoms, and that they would come in for testing if they feared a risk of exposure, specifically if they found out their boyfriend had been cheating on them, if they had a condom break or if they had had unprotected sex. Women were more likely to seek asymptomatic testing for "peace of mind."

Things happen—mistakes. A rubber popped, that's why I came in today. *I'm terrified, and I have dealt with this person for awhile, and I think they are clean, but I can't take chances. There's too much going on in the world today.*

—27-year-old white female

For both sexes, that heightened sense of risk, despite efforts to protect themselves, came because they:

- Suspected or learned that a partner had an STD
- Heard or knew a partner was "sleeping around"
- Had a condom break, or were unsure if it had broken
- Had sex with multiple partners
- Did not know their partner well or had anonymous sex
- Had sex "under the influence" of alcohol or drugs

One 18-year-old African-American man said, for example, that "having sex with multiple people, unprotected or not," would give him the feeling that he should be tested for STDs: *You could have a rip in the condom and you wouldn't know*.

Testing Among Partners

Most patients, male and female alike, admitted they would prefer not to use condoms, but only a few said they now seek routine STD testing for assurances that they are "clean" and would not "give anything to anybody." Others said it has become their practice to urge their partners to be tested.

- ***Attitudes about discussing STD testing with partners were generally positive, but some fear or have experienced conflict.***

Although white and African-American men appeared open to questions from partners about whether they had been tested, Latino and Asian men more often said they would be insulted if a partner asked them if they had ever been tested for STDs.

Many patients said, however, that they had asked partners if they had been tested and they had been asked as well. Being asked or having questions answered was considered a positive sign that partners cared about each others' health and well-being. Refusals to answer questions from partners, however, raised significant concern about potential risks.

Yes, I've asked [a partner if he had been tested]. *He didn't like being asked. I think it's ignorance. My friend says he only sleeps with nice women, decent women. But I said, 'You don't know who they slept with before you.' He was insulted.*

—32-year-old Hispanic female

I never asked before, but I am going to ask my boyfriend. I'm going to ask because I got it. *I want to know where I got it from. I don't know what the reaction is going to be. Probably, 'What?' He should have come here with me today.*

—43-year-old white female

- ***A few patients reported that, in new relationships, they used condoms at first, then went for STD testing, sometimes together, so that they could discontinue condom use.***

I use [condoms] all the time, but at least for the first three months. *Then I usually try to get them to see a doctor. I make sure I see the card the doctor sends back that everything is normal. If I can provide [the card], then they can too, but men don't go see the doctor like women.*
—27-year-old white female

My husband and I both got checked. *If I did end up with something after that, I would know he was the one who did something.*
—26-year-old Native-American female

However, their strategies assumed monogamy within their relationships, which they sometimes knew or suspected was not the case. Men in these interviews and focus group sessions were more likely than women to admit having sex outside of their longer-term relationships. In these cases, men said they did not use condoms with their girlfriends, but did use them with the other women with whom they had sex. In fact, most women who had tested positive for an STD or sought STD testing said they were prompted after learning that their boyfriends had been "cheating on me."

- ***A few, both men and women, said they had been tested for STDs together with their partners before starting their sexual relationships.***

Both go out and get checked out if you plan on being with that person. *That's the best way to not get STDs.*
—Male focus group participant

I'm comfortable with asking about testing. *I have asked partners about testing because I thought it was going to be a serious relationship and I wanted to make sure it would be possible to have unprotected sex.*
—24-year-old Hispanic female

In describing their motivations for suggesting or agreeing to be tested with their partners before having sex, they acknowledged wanting to avoid condom use, but said they had a strong desire to "start the relationship clean." Not only did this provide them a sense of security in knowing they were not at risk of acquiring an STD and would not be putting their partners at risk, they saw opportunities to build trust and strengthen the relationship. They believed their partners would be less likely to "cheat" or would at least always use protection if they did have sex with someone else to avoid the risk of bringing an STD into their relationship.

Provider Risk Assessments and Feeling Judged

Generally, patients felt the health care professionals who treat them are comfortable discussing sexual issues and consequently make them feel comfortable as well, though many expressed concerns about potential judgments of them relating to admitted sexual behaviors. Staff at STD clinics were seen as being particularly adept at asking questions sensitively and giving patients appropriate information. Patients commented that the nurses and doctors "wouldn't have this job if they don't feel comfortable" discussing intimate and sexual issues.

- ***Both men and women typically said they prefer to have providers of the same sex, particularly for sexual health issues.***

When looking for health care services, some women said they would ask clinics "who the female doctors are" because they found male physicians to be "rougher." Men often said they feel awkward around female providers, but as one young man pointed out, every person at a clinic he had gone to, from providers to nurses to support staff, was female.

Patients in the age group targeted for this research sometimes also expressed a preference for "younger" providers, because they expected them to be "less judgmental."

Overall, most patients trusted their providers to provide them with good care because "they are the experts." They also generally believed that providers are comfortable having discussions about STDs and sexual behavior, though others were less certain. Some patients voiced harsh criticism of what they perceived as "judgmental" reactions from some clinicians, who they thought should be "trained not to raise their eyebrows." *They ask all the questions they have to ask, seeming open-minded,* one woman said. *They ask, 'Do you do this?' And you say, Yeah. And they're startled. And they get flustered.* As a result, patients said they sometimes withhold information.

If I answer their questions about how many partners I've had, *then I think, 'you're giving me a look,' like 'that's high' and I don't even think that's high.*
—Female focus group participant

- ***Detailed risk assessment questions, whether in print or asked orally, evoked the most negative reactions from patients.***

While patients said they assumed that questions about their sexual behaviors are being asked to assess their health and risk, most emphatically said they dislike those questions, saying "it's private information." Some did say they preferred answering STD risk assessment questions in writing on forms, rather than responding directly to providers.

I've been coming here so long I know a lot of the doctors. *I used to be scared. Now I feel they can help us out. If I'm scared, I put it on a piece of paper and they can read about it. Now, it's not hard to talk to them.*
—21-year-old African-American female

Some who were are at clinics to be tested for STDs said they do not understand the point of the risk assessment questions. They even admitted not being truthful, particularly about the number of partners they have had, and withholding information when they believe the questions are unrelated to their visits.

I don't want to sound like a slut, so I've lied *[about the number of partners I've had].*
—Male focus group participant

Questions about body piercing and tattoos seemed particularly odd to some patients, making them feel as if they were about to be judged for their body art. And heterosexual men, especially, said they do not like being asked about gay behaviors.

- ***However, the majority of patients, especially younger ones, said they are very comfortable telling providers the "whole truth" about sexual issues.***

This is particularly true, they said, when they have concerns, because then "they can be helped." They said that they understood the reasons for the questions and felt "very comfortable. If you want to know it, I'll let you know." A 26 year-old African-American male remarked that: *They ask questions to get a better idea of what's going on—to make better judgments.*

Certain things I'm iffy about. I'm even embarrassed to tell them I'm gassy*. Talking about conventional sex is one thing. Unconventional I don't discuss. I don't know why. If the doctor asked me, though, I'd probably say yes or no.*
—38-year-old white female

Yet, they confessed that sometimes they do not feel good about their answers—they have to admit to themselves behavior they see as incorrect—and they expressed added concern about being judged.

- ***Importantly, some patients said that even though they had come to the clinic specifically for birth control or STD testing, they did not complete either a written medical history or sexual health questionnaire, nor were they asked risk assessment questions by providers or clinic staff.***

Sometimes when I get a physical, they'll say, 'Use a condom.'
—28-year-old Hispanic male

Although providers typically reported that, on the whole, all patients, including those coming for STD testing, are asked STD risk assessment questions routinely, many patients could not remember having completed a written medical history, regardless of the reason for their visit. In some cases, patients said that providers had asked them a few questions, but there appears to be a conflict between providers' reported procedures and what patients recall from their encounters with providers at clinics.

They didn't ask me questions today*. I came for a Depo shot and an ear infection. They've asked in the past.*
—22-year-old African-American female

The doctor just asked if I [was sexually active]. *She might not have asked the other questions because I ran my mouth and what I wanted to know. She might have had the answers before she asked.*
—27-year-old white female

Fewer than half of the patients interviewed at clinics recalled being asked whether they were sexually active or had ever tested positive for STDs, and only one in three said they remembered being asked about their use of IV drugs, sexual orientation, the number of partners they had had, use of protection, types of sex in which they had engaged or birth control methods.

- ***Embarrassment and concerns about confidentiality leads some patients to seek sexual health care at facilities other than their "regular" clinics or providers.***

Some patients said they prefer go to anonymous STD clinics, to avoid having to discuss their sexual behavior with providers they know and to prevent any possible reports of drug use or diagnoses of STDs from appearing on their "permanent record" or being passed on to other authorities.

I wanted to go to an in-and-out place that was confidential. *The Red Door didn't ask a lot of questions. They just asked what I wanted to be tested for. I came for that purpose.*

—Male focus group participant

STD clinics were perceived to be "very good" at dealing with sexual issues in a confidential and sensitive manner. Patients typically said staff at these clinics was well-trained, "put you at ease" and there was no sense of embarrassment in discussing STDs. The Red Door clinic was again sometimes cited as an example. One woman, for instance, remarked in a focus group: *The woman there was really good at talking through things.*

Testing Procedures and Treatment

Patients in these interviews typically understood what was involved in being tested for STDs. Women were familiar with gynecological exams. Most men spoke about having to "pee in a cup." While few expressed concern over these testing procedures, patients were more likely to describe emotional issues that impacted their attitudes toward STD testing. Importantly, patient apprehension about STD testing was sometimes heightened because they did not know what the treatment would be if they tested positive for an STD.

- ***Very few patients in interviews at clinic sites or in focus groups perceived STD testing procedures to be invasive.***

Women in one focus group session, for example, when prompted about their testing experiences, seemed resigned to the "hurt" and "scraping" associated with some STD tests, but few could suggest improvements to STD testing procedures other than to say that "women need results sooner."

[STD testing] seems pretty simple. It's just blood and urine.

—22-year-old white female

For a very few others, their only request for less invasive testing procedures involved "getting rid of the needles."

In contrast to the dread that often tops the lists of men's fears about STD testing, "the stick" was only referred to by a few men in these interviews as a way of explaining how excited they were about its replacement with urine tests.

I got a urine test. They don't use that stick anymore. *I just wish they could get rid of the needles.*

—Male focus group participant

- ***Lack of information about STD treatment, however, seemed to prompt greater anxiety among some patients than concerns about invasive testing.***

I need to know more about everything, like the STDs—the treatments.
—32-year-old Hispanic female

Frequently, patients revealed that they knew treatments for "incurable" STDs, citing HIV/AIDS and herpes, were difficult or non-existent, but had little information about how other STDs were treated. Often, that uncertainty appeared to increase their concerns about STD testing and what treatments they would have to endure if they tested positive.

It is notable, then, that when the ease of treatment with antibiotics for the most common STDs was described by one woman to the relief of others in a focus group session, it had a dramatic effect on making STD *testing* less threatening to them.

In other cases, though, the idea of "taking a pill" to cure an STD seemed to diminish the perceived need for persistent use of protection.

- ***Patients sometimes described the emotional conflict or barriers they experience when confronted with the possibility of or recommendation for STD testing.***

You wouldn't want your partner to know if it was positive—*that you have that kind of disease.*
—35-year-old Hispanic female

These emotional barriers often rested on a fear or assumption, unfounded or not, that they would test positive. Both men and women said their reluctance to be tested for STDs stemmed from:

— Fear of telling a partner that they been tested and the consequence of rejection

— Confronting evidence that a partner cheated on them

— Fears associated with HIV/AIDS, hopelessness and "not wanting to know"

— Confirmation that "I should have known better, but failed to protect myself"

Perception of Provider Recommendations for STD Testing

Reports from patients on health care providers' practices relating to STD testing recommendations were varied.

- ***Although most men said providers had suggested, either during their current visit or sometime in the past, that they be tested for STDs, many said recommendations for testing only occurred when they had gone to the clinic specifically for STD testing or because they had symptoms.***

The doctor asked if I had any concerns or symptoms. They just said it was time to do it again. *I was asked what I would like. She said we can test for . . .and went down the list. She left it open.*

—38-year-old white male

In one focus group session, several men claimed they had been to clinics for routine physicals, without STD symptoms, but did not know whether they had been tested for STDs until after their results had been reported. One commented that *they told me to pee in a cup and then took blood. I thought they thought I was having sex with everybody, so they were testing me for everything.* Another confirmed: *They don't tell you ahead of time*.

- ***Women, in contrast to men, reported more varied experiences with provider recommendations for STD screening.***

As noted, many women assumed they are routinely tested for STDs when Pap tests are administered. And they assumed they have tested negative when they have not been otherwise notified. But other women were uncertain about whether STD tests were conducted and some said their experience was for providers to ask them, "What STDs do you want to be tested for?"

They usually tell me about testing [during Pap tests]. They ask you what you want to be tested for. *I didn't [get tested] because it costs extra.*

—Female focus group participant

According to a few women, providers would ask about conducting specific tests because the costs of, and insurance coverage for, tests vary. Other women noted they had requested STD testing before it was mentioned by providers.

Older female patients and some who were married were less likely to say that providers had specifically suggested STD testing to them. A 43-year-old African-American female, for example, said she came in with a urinary tract infection and felt that she should have automatically been tested for STDs. She suggested that STD testing "should be more routine."

- ***Both men and women were in strong agreement that when physicians explain why and what they are doing, their comfort level, particularly relating to STD testing, increases substantially.***

It's like they're just giving generic answers*—doesn't want to take time to ask me questions or answer questions I have.*
—Male focus group participant

Men frequently thought most physicians are "just doing their jobs," and usually exhibit little interest in them personally. A few said they quickly make negative judgments about providers when there is no small talk at the beginning of an examination. Physicians were seen by some to be goal-oriented and more likely to use technical or medical terms they do not understand. In contrast, one woman remarked, "It's always a good sign when they take their time," noting that "nurse practitioners never look at their watches."

The doctor told me I had HPV and walked out of the room. *I didn't know what it was. I was 17, living at home. I had to go home and tell my mom.*
—Female focus group participant

CHAPTER THREE:
Provider Policies and Practices

I have to say that I am in touch with the Minnesota Department of Health, *and our rates were the highest, I believe, last year in any of the cities and probably any area in the state.*

—Community clinic provider

[STD rates are increasing because] of a lot of young people who have unprotected intercourse for a variety of reasons. *Many do not see doctors often . . .and don't even know that urine tests are now available for testing boys and men.*

—Community clinic provider

As health care professionals at STD, family planning, community, school-based and specialty clinics, providers interviewed for this research were highly attuned to the prevalence of STDs among the patient populations they serve, particularly among adolescents and young adults. Most said they perceive STD rates to be rising in their communities as well. Any *stability* in high STD rates that some observed was attributed to "cycles" that "bump rates up and down year-to-year," to increased condom distribution at school-based clinics and to improved patient education.

Several providers, notably those at school-based, family planning and community clinics, attributed their perceptions of *rising* STD rates to their own efforts to increase STD testing and outreach to high risk populations in their communities. Generally, however, providers typically ascribed the increase in STDs to "adolescent immaturity," unprotected sex, promiscuity and lack of routine health care.

STD Screening and Treatment Guidelines

We do the best we can [to follow treatment guidelines]. *Sometimes we may not have available the number one choice of drug, but we stay within guidelines.*

—Adolescent clinic provider

All of the providers interviewed said they are familiar with and follow—"to the letter"—the 2002 CDC STD Treatment Guidelines. Any exceptions noted by providers at a few adolescent or STD clinics only meant that they "went to the second or third approved treatment drug" because of undefined "insurance issues" or "what we have available" to provide to patients.

- ***Providers said the STD risk assessment criteria they use to determine who they will screen for STDs are based on guidance from a variety of sources.***

We have our own guidelines *[on STD risk assessment criteria], but it is based on the CDC guidelines.*

—Family planning provider

Among the sources they cited were the CDC, HEDIS, the U.S. Preventive Services Task Force, the Minnesota Department of Health, the American College of Obstetricians and Gynecologists and an assortment of other professional organizations and journals. Several said they also go beyond these sources and have developed their own risk assessment and screening criteria and instruments.

I check in with local OB/GYNs and family physicians to hear their screening guidelines. *We do individually what we want to do. We're a clinic under ICSI.*
—Community clinic provider

A few community clinic providers indicated that use of formalized STD risk assessment and screening guidelines at their clinics was "not systematic" or was an "individual provider's decision."

- ***Experience with the ICSI Health Care Guidelines was limited.***

Only one community clinic provider reported using ICSI guidelines: *We have contracts with managed care plans . . . and we try to be in compliance.* More than three in four providers, however, said they were "not very" or "not at all" familiar with ICSI guidance on STDs. *We all have them, but I'd have to say that I don't necessarily use them for that,* one said. Several providers, usually at STD and family planning clinics, noted that they do not pay much attention to or refer to ICSI guidelines because they are not primary care facilities.

Changes in Clinic Practices

According to all but a very few providers, various changes in STD testing practices had been instituted at most of their clinics over the last few years, often resulting in increased levels of patient screening.

- ***Use of urine tests for chlamydia and gonorrhea was the most frequently noted positive change in clinic testing practices.***

We don't see many teen boys, *but when we see them, they are willing [to be STD tested because of the urine test].*
—Community clinic provider

Several said the switch to urine-based screening had made a "dramatic difference" and that, as a result, they are now testing "asymptomatic women routinely" along with "a lot more" patients in general. But the move to chlamydia and gonorrhea screening using urine tests was not universal. Those who do not have urine-based screening available raised several specific issues:

I don't know why [the urine test] is no longer available. *We had more young men then who'd pee in a cup. Now there are fewer who will have the test because of the discomfort of the probe.*
—Community clinic provider

— One provider with an exclusively female patient base expressed some limited interest in making urine-based screening available, but also said that *our patients are motivated enough to come in and they don't mind the pelvic exam, so that's not a barrier.*

— A few providers with high proportions of uninsured patients said urine testing was not available or had been discontinued because of financial issues.

— One noted the possibility of urine-based tests increasing the potential for fewer visual exams in both men and women and that abnormalities may be overlooked.

— Another reported that urine-based testing had been considered, but was rejected because of lab concerns about the levels of false negatives.

Using the urine sample has made a difference [in testing rates]. *We have to train nurses to get the right sample. They must get an early sample.*
—Community clinic provider

This concern about urine test reliability contrasted with the views of another provider who is also the clinic lab director. *We researched and the lab test that was done on urine is almost as accurate as the swab up the urethra, so I think it's a good test.* Other providers did note, however, that sample collection required some degree of precision, necessitating additional diligence on the part of nursing staff.

- ***More aggressive screening of adolescents and females was also seen as a particularly important change in recent clinic testing practices.***

As one provider said: *We do much more screening of teens and single women when they come in for a physical or birth control. I used to offer it. Now I say you need it.* This emphasis—"we really push," another provider stressed—was variously attributed to:

— Implementation of HEDIS guidelines for chlamydia screening of 16- to 26-year-old sexually-active women

— Guidance suggesting that all women, regardless of age, should be screened if they have had a new partner and do not use condoms 100 percent of the time

— Providers' own perceptions of elevated and increasing STD rates among their adolescent patients

We have HIV—a rapid HIV now. *Results in 20 minutes, which is wonderful as a preliminary screen.*

—Community clinic provider

- ***For a few providers, use of DNA probes for chlamydia and gonorrhea screening were among the "biggest changes" they had seen in the past few years.***

Other providers, on a more limited basis and most often at community clinics, also mentioned recent changes which they viewed as key, including:

— Increased focus on HPV screening and typing of women with abnormal Paps to determine those with higher- or lower-risk HPV

— Use of OraQuick® Rapid HIV testing as a screening tool

— Routine STD screening for chlamydia and gonorrhea on the first pre-natal visit

— Use of the ThinPrep Pap test

— Clinic reorganization as a walk-in facility

And for one provider with a large adolescent patient base, the biggest change in clinic practices was negative: *We used to do HIV, gonorrhea and syphilis testing for free. Now there are no longer state funds for that. We have to figure out how to give kids the confidential test advocated by law by the state.*

Assessing Patient Risk

In the decision-making process for determining who they test for STDs, provider practices were remarkably consistent in some areas and varied considerably in others. Most consistently, providers reported vigorous efforts to screen all sexually active adolescents and young adult women. The variability in provider approaches to decisions about STD screening were often a function of the type of clinic in which they worked.

- ***At all clinics, basic questions about sexual health and recreational drug use were included on the customary medical history intake forms.***

Most often, these forms were designed to be completed by patients themselves on their initial visits. At minimum, and usually at community clinics, they asked patients if they were sexually active, about the types of birth control and protection they used and whether they had any history of STDs. One

community clinic provider volunteered, however, that the sexual health questions were "not asked well" on forms at her clinic.

STD and family planning clinics were more likely than community clinics to include on intake forms much more detailed sexual health questions, including any new sexual partners in the past year, types of sex, sexual orientation and use of recreational drugs.

For sexual health issues, some providers said their clinics use ancillary questionnaires tailored to patients' sex and age. Use of teen risk assessment forms, for instance, was particularly common among providers at community and school-based clinics. Typically, the AMA's GAPS (Guideline for Adolescent Preventive Services) form or other forms based on the GAPS model were used to seek information from adolescents on specific sexual behaviors, history, attractions, gender, sexual orientation and alcohol and drug use.

- ***Providers frequently indicated that even when detailed risk assessment questions were included on intake forms, they preferred to obtain most of that information during their initial interviews with patients.***

We don't have an 'intake' form. *We do it all verbally.*

—STD clinic provider

Providers at most STD clinics, as well as at some community clinics, said that patients do *not* complete even basic intake forms themselves, but are interviewed by nurses, counselors or physicians.

One community clinic provider indicated that an as-yet uncompleted transition to EMRs—electronic medical records—will replace the "piece of paper that the patient fills out." *I think it will be more accurate,* he said, *because the doctor is now going to have to ask those questions, as opposed to the patient that was sitting waiting for the doctor. But I'm not sure it's going to be faster.*

We ask all the questions all the time.

—STD clinic provider

At STD, family planning, adolescent and school-based clinics, providers said they were absolutely rigorous about asking patients they are seeing for the first time the full battery of risk assessment questions: whether they are sexually active, their methods of birth control, STD history, use of protection, number of partners, recreational drug use, types of sex and sexual orientation.

The same questions are asked on follow-up visits, *unless they are coming in more than once a year, but they'd be asked all but about drugs regularly, even if more than once a year.*

—School-based clinic provider

Asking patients about IV drug use, however, was seen as particularly problematic. Providers at all clinics noted "distrust from clients" about responding to questions about IV drug use

The form asks about recreational drug use, but we won't ask about their specific drug use. *They don't accurately report that anyway. It makes them nervous when you ask. They think you're going to call the police. Stoned kids say they don't use drugs.*
—Family planning clinic provider

specifically. If patients did indicate recreational drug use, several providers said, they were sometimes inclined to ask more detailed questions. But one community clinic provider admitted that by *not* routinely asking about IV drug use, she had been unaware of one patient's IV drug habit "for a significant time."

- ***Providers rarely reported any difficulty in talking to their patients about sexual behaviors, although some noted that patients sometimes wonder why they are being asked "all these questions."***

Typically, providers said they encounter little resistance from patients, particularly younger ones, about discussing sexual issues. One quipped, however, that women in their 60s are "not amused" by questions about their sexual activity. As revealed in interviews with patients, several providers said they do have patients who say, "I've done this before. Do I really have to answer all these again?"

- ***But not all providers ask all STD risk assessment questions of all patients.***

Under some circumstances, depending upon what they come in for*, I'll ask most of those [risk assessment] questions. But if somebody came in with a sore throat, I wouldn't necessarily go there. I would have to admit that I've missed some very relevant information on some people for very long periods of time by not asking. Pre-natal people get asked all that and adolescents do. For physicals, they do get asked haphazardly. If you had reason to ask one of those questions, you are probably going to [ask] all of them.*
—Community clinic provider

At family planning clinics, for instance, providers say they routinely seek a full range of information on sexual health from women. But men, who were said to typically arrive at family planning clinics seeking STD testing, were only administered an "abbreviated questionnaire related to the risks of infection."

At community clinics in general, providers were less consistent in asking patients about sexual orientation, types of sex and IV drug use, unless they perceived reasons to pursue those issues. In fact, at one community clinic a provider said that *different doctors do different things. There's a form available, but providers can do what they like.*

One specialty clinic provider adamantly said she does not ask questions about STD history because *we're <u>all</u> at risk and previous history doesn't predict. I don't want to be invasive or judgmental.*

If a person comes for an episodic visit, I ask about their healthcare generally *and try to get some more information. I ask what kinds of protection they use and offer condoms to them without Nonoxynol-9.*
—Community clinic provider

Although community clinic providers without exception said they always ask STD risk assessment questions of adolescent and prenatal patients, some acknowledged that risk assessments of other patients are "haphazard," even when patients have come for physicals. They do not complete full risk assessments of every patient, and when they do not, it is often related to the

The time issue [on not asking patients STD risk assessment questions] depends on why they came in to see me.
—Community clinic provider

[We don't ask all the risk questions] if they're coming in for a cold. *We do go through their past history and I always ask the drug question. It's a time issue if they've come in with asthma, say.*
—Community clinic provider

It's more common that women expect screening. *Men are not terribly resistant with the demise of the probe. Teen girls hate pelvic exams, so we use urine testing a lot. If they think it's confidential, they're more open.*
—Community clinic provider

Symptomatic or not, women are routinely tested *for chlamydia, gonorrhea and syphilis, wet mount if indicated. Same with men, as part of screening. Whenever a patient wants HIV, HIV and STD services are combined so they don't need to come back.*
—STD clinic provider

We recommend STD testing with annual visits because of the age of the patients, *the high incidence of multiple partners with teens nowadays. When girls are diagnosed with warts or herpes, they cry. They have never really accepted that they are at risk.*
—Specialty clinic provider

Re-screening is one on one. *There are some kids we see every two weeks for pregnancy tests, but we don't re-screen unless they have a new partner.*
—School-based clinic provider

nature of the patient's visit and time pressures. They said they typically do not assess the STD risk of patients:

— Who come with a specific, non-related problem, like a cold or sprained ankle

— For single, repeat visits for birth control

— Who come specifically for STD testing, whether they are asymptomatic or not

Determining Who To Test

Providers uniformly recognized that from a public health perspective, STD screening guidelines that recommend, for example, chlamydia screening for all sexually active adolescents and young women make sense. Providers routinely said they follow accepted guidelines and offer STD screening to all sexually active adolescents and young women, regardless of other risk assessment criteria.

Notably, only one provider at a community clinic attributed any failure to follow screening guidelines to "physicians-in-training" who are not familiar with them or to nurses who "forget to set out a chlamydia test."

- ***Some providers reported that when they do not follow established screening criteria, it is because they are being more cautious than guidelines recommend.***

One provider noted, for instance, that they re-test for gonorrhea after treatment, even though guidelines do not suggest it. *We know there's a high risk of re-infection, so we do it.*

- ***Very often, providers said that their decisions to offer, recommend or perform STD screening were based as much on patient age and the reason for their visit, as it was on any assessment of patient risk factors.***

At STD and school-based clinics, providers frequently said risk screening guidelines were irrelevant because *we screen 100 percent of patients. That's what we're here for*, one provider said.

Admittedly, however, providers at other clinics said they may be less forceful in their recommendations for STD screening when risk assessments do not suggest elevated patient risk. Nevertheless, providers typically said they routinely screen asymptomatic women who:

- Ask for birth control
- Are a partner of someone with symptoms or previous STDs
- Ask for a pregnancy test
- Express concern about STDs
- Have abdominal pain or signs of a urinary tract infection
- Are having annual exams

I offer [STD screening] to everyone, *but mostly it has to do with their sexual activity level or IV drugs, mainly.*
—Community clinic provider

We don't force any STD test, but it is highly recommended they get tested. *We use the birth control opportunity to press that option a little.*
—Adolescent clinic provider

- ***Provider reliance on patient reports of monogamy decrease the likelihood of STD screening in asymptomatic women.***

If a patient is in a long-standing relationship *I am less likely to STD screen.*
—Specialty clinic provider

Some providers acknowledged that, in the absence of symptoms, they would not screen a monogamous woman with no risk factors. As one provider said, however, *all women should be tested if they have had a new partner and don't use condoms 100 percent of the time. This is a critical criteria.*

It's a value judgment [in deciding who to screen]*—not married, maybe lying, several partners—as opposed to the age group that usually gets screened. I wish it was 'when I do a Pap, I always test for STDs.'*
—Community clinic provider

Other providers agreed that they are much less likely to screen older women unless they are symptomatic, and that asymptomatic older women are much more likely to choose not to accept the offer of testing.

- ***Asymptomatic non-adolescent men are offered screening more routinely with the availability of urine-based tests.***

There are no barriers much, really. We offer [non-invasive] tests they accept. *Sometimes, though, some patients feel because [they recently had a test] it's unnecessary.*
—Specialty clinic provider

The majority of community clinic providers indicated that in the absence of symptoms, they routinely screen men for chlamydia and gonorrhea. As one provider said: *Some clinicians here offer screening now when guys come in for sports physicals. The urine test has made it much easier.*

- ***When patients are not screened, they said, it is often because "patients have the right to refuse testing" and they do refuse because of cost and issues of confidentiality.***

Even though providers indicated they make strong efforts to comply with accepted screening guidelines, in the real world some said they face obstacles to meticulous compliance with these guidelines. Providers said they sometimes ask themselves: Will insurance carriers pay for that? or Will people pay cash for something they feel they are not at real risk for?

I encourage chlamydia testing. *But patients do not understand chlamydia and want to avoid a bill going to parents, or it could be the cost of the test. They refuse it.*
—Community clinic provider

Community clinic providers noted that some insurance programs, like Medicaid, do not cover all testing. When asymptomatic patients are confronted with paying out-of-pocket for tests that they are not convinced are necessary, or that they may have recently had, they decline to be tested.

The time issue on [not asking patient STD risk assessments] depends on why they came in to see me.
—Community clinic provider

A very few providers also remarked that, in some cases, their efforts to detect and treat STDs were hampered by patients who have tested positive for an STD, but do not accept offers of free medications for their partners or to those who continued to avoid STD testing because they were "not aware that we use urine tests now."

Sometimes when they're worried they won't come in *because of [confidentiality concerns] or they go to the emergency room instead.*
—Community clinic provider

More often, however, providers noted that when they encounter resistance to recommendations for STD screening, it sometimes stems from concern about confidentiality, particularly among younger patients.

Strategies to Ensure Confidentiality

With the lone exception of a provider at an anonymous STD testing site, providers all said younger patients have expressed concern about issues of confidentiality, particularly that parents will find out through insurance reports that they have been screened for STDs.

- ***Providers reported that when patients have symptoms of an STD, or are concerned that they may have been exposed, they frequently opt to seek care at an STD clinic.***

As noted earlier in this report, patients use this strategy to avoid having any possible diagnosis of an STD or drug use that may turn up in urine samples documented on their "permanent records." A provider at one anonymous STD testing site, for example, noted having patients that come for STD testing in

advance of appointments with their regular providers, just to make sure they are STD free.

- ***Providers admitted they have devised strategies to overcome the confidentiality concerns of their younger patients.***

I have no control over the insurance, *but I can send them to the local clinic for free screening. I leave my name only, set it up in advance, so parents don't know.*
—Specialty clinic provider

Some spoke of insurance company "confidentiality codes" intended to ensure that patients' parents or other family members would not be aware of billable tests. However, one provider commented, "I'm not in charge of the insurance companies." Recognizing that she could not guarantee the confidentiality of younger patients, she said she made appointments for them at a nearby free STD testing site in her own name.

As another provider described it: *Some insurance companies don't use descriptions for [STD tests] But there are not good codes to note that this isn't billable. We simply write some [STD testing] off.*

Yet others reported that they set up separate accounts for younger patients in their own names so they "can pay for it themselves." If parents are paying, some providers indicated they will use codes that result only in an itemized bill for office visit-level "lab tests."

Managed Care Barriers

Providers at STD and family planning clinics often said they "don't get involved with managed care organizations" because they are not primary care providers. Providers at community clinics, however, were sometimes quite vocal about some managed care issues they perceived as barriers to increased delivery of STD services to their patients.

- ***Notably, many community clinic providers had positive comments about Minnesota publicly funded managed care programs.***

Some providers saw few barriers in their relationships with managed care organizations. *We love it that they're in a publicly funded managed care program, even though the reimbursement rate is low,* a community clinic provider said. *At least we're getting something. So many are uninsured.*

- ***More often, providers criticized managed care programs because of confidentiality issues.***

There should be a way, many providers said, to make bills non-specific to protect a person's privacy, not only for adolescents, but for people who might be having an affair. As one provider said: *Insurance companies are not supposed to send out bills to confidential codes, but we can't guarantee it.* Others urged more "generic" references to STD tests, "like test #5."

- ***Many providers raised reimbursement issues.***

[Managed care] should reward us [with reimbursement] for using guidelines of good practice, *i.e. testing for STDs. For instance, some managed care companies reimburse more for treating diabetics.*
—Community clinic provider

A lot of billings are rejected, one provider said. *They pay zero and don't even justify it. We're credentialed through managed care providers. We don't report for adolescents and have to pay for it.* Others asked that school clinics be reimbursed fully. One school-based provider commented that: *Kids can't go to managed care clinics for confidentiality reasons. We're doing their care for them without reimbursement.*

- ***Others cited restrictions on screening and treatment options and the difficulty of getting referrals accepted.***

The need is for full reimbursement for STD tests from managed care organizations.
—Adolescent clinic provider

Several providers urged that urine-based screening be reimbursed, and those outside of the managed care system asked for more funding for urine-based screening, particularly because of its value in increasing testing rates among younger patients.

[With managed care] there are restrictions on treatment options and the drugs you can prescribe [for STDs].
—Specialty clinic provider

A few were uncertain, but believed that the top STD treatment drugs were not always reimbursed by managed care.

Referral problems were noted by others. According to a family planning clinic provider: *If we do the Pap and need a referral, their physician doesn't want to do a referral.*

CHAPTER FOUR:
Education and Prevention Efforts

As noted earlier in this report, the twin STD-prevention messages of condom-use and abstinence are well-known, quickly cited methods to reduce the risk of acquiring an STD. Rising STD rates, however, belie the impact these messages have had on actual behavior. Patients and providers alike agree that abstinence is "not realistic" once a person has become sexually active and condom use is inconsistent.

It is notable, however, that *monogamy* has not risen to the same level of consciousness as condom use and abstinence. While it is not surprising that most patients suggested more flyers, billboards and commercials to help people avoid getting STDs or get checked out faster, a few proposed that *monogamy* be promoted with the same intensity and skill that condom use and abstinence have been.

Providers can be influential sources of information about sexual risk reduction, especially for adolescents. But as one community clinic physician commented: *I think sometimes the effectiveness of our efforts is frustrating. I mean, how can you get through to people?* A woman in one focus group agreed: *It all seems like common sense. I don't understand why people don't get it.*

Provider Efforts

Most providers interviewed in this research reported in various contexts their efforts to reinforce prevention education with patients. Many said they use follow-up visits with patients to urge continued condom use, to encourage patients to raise questions or concerns and to educate them about their risks.

One provider observed, however, that: *Kids expect dishonesty from adults. They think we overstate the risks so they won't do things that are fun.* More often, this provider implied, providers and educators talk to kids, rather than listening to *them* talk about what is "really going on out there."

- ***Notably, patients who were interviewed commonly reported only minimal discussions with providers about STDs.***

Frequently, patients said only that their providers "asked the questions on the form" or talked to them "just for a brief moment." More often than not, these conversations came in the context of patient-motivated visits for STD testing. As one 24-year-old Hispanic woman said: *I came in for testing. That's the only time a doctor talks with you about STDs. Not on regular checkups. I brought it up.*

- ***Asked if they had heard, seen or read anything that made them think differently about STDs, most often their reply was "nothing really."***

Knowing people with HIV/AIDS and a general awareness of the disease, patients revealed, had a greater impact on their attitudes toward STDs than any of the more academic information on prevention. At the same time, a few patients, often African-American men, volunteered that some brochures or flyers had been a valuable source of specific STD information for them.

Brochures

Providers frequently reported that their most successful education and prevention efforts were the brochures and flyers that were available throughout the clinics. "We keep running out of them" was a common comment from providers.

- ***Most patients said they had seen these materials at the clinics they visited, but few said they had made any impression on them.***

As some patients observed, people who notice, pick up and read these media materials are those who already have a heightened interest, those who "are already thinking about it."

Others found it doubtful that they would look at brochures about STDs in a waiting room full of other patients, but are more receptive to reading or taking that information home with them if it is given to them by providers or they find it in a private exam room.

A selection of the brochures available in different clinics was given to patients in some focus groups to review. Generally, these patients said that "ones that tend to be more factual are

better." Patients said they just wanted the facts: how you get it, what the symptoms are, where to go for treatment. Patients were particularly attracted to brochures that were straightforward, not overly slick or glossy.

Some of the brochures were quickly derided, especially those emphasizing abstinence like *101 Ways To Make Love Without Doin' It* or *The Choice To Abstain*.

- ***Notably, brochures targeted to the gay community or that incorporated images of people of color triggered some of the most positive reactions among patients.***

Women in one group said the gay-directed brochures were the only ones that clearly communicated information about the risks of *oral sex*—information that they did not know. *This information should be more widely disseminated. We should be getting this information, not just gay men.* While patients agreed that they responded positively to, and expected, print materials that featured images of "people like me," brochures that included *only* people of color were seen as unfairly targeting certain groups within the population.

Common Myths

Many of the stories circulating among patients, and which they are uncertain about believing, continue to connect directly to their concern about HIV/AIDS. On one hand, these stories highlight the need for continuing education efforts, and on the other, they demonstrate how ineffective some communications have been. Some said they have heard, but do not know whether it is true, for example that:

- If you kiss them, you get AIDS
- You can get AIDS from mosquito bites
- You cannot get AIDS with a condom
- You can get really skinny and lose weight from STDs

Patients also reported other hearsay that prompted uncertainty and questions, including rumors and stories that:

- You cannot get anything orally
- Only dirty, nasty people get STDs
- You can get crabs from a toilet seat
- When you catch an STD and eat beef, it "irritates" the disease

Promoting Partner Testing

Though some men and women were skeptical about whether it could be effective, others believed there should be a greater effort toward encouraging partners to "start clean" by getting STD tested at the beginning of new relationships. In fact, some indicated that they and their partners had been tested before becoming sexually involved and that, despite their initial apprehension about partners' reactions or arranging for testing, their decisions proved to be beneficial to their relationships and peace of mind.

And in support of this idea, other men and women strongly indicated that if they and their partners were tested together—and they knew that neither had an STD—they would be far more careful about what they do on the side and much more uncompromising in practicing safe sex *outside* of those relationships.

Men in focus group sessions frequently reacted to this scenario by saying that, while they would probably not resist a suggestion by their partners that they be tested together, they also would be unlikely to initiate the request.

APPENDIX: Managed Care Organization Comments on the Report

Contracted Managed Care Organizations (MCOs) are provided the opportunity to comment on the study report and have a summary of those comments included in the final report. Three of the seven MCOs submitted comments. The following is a summary of MCO comments submitted to the Minnesota Department of Human Services (DHS).

Methodology and Content

- "The methodology and content of *Sexual Health Care: Motivators and Barriers* are excellent. Given the size of all the respondent groups, the researchers appear to have reached a very respectable number of providers and patients. The report is written in a 'voice' that gives the reader a feel for the individuals and populations interviewed."

- "(Our MCO) finds the study methodology and interviewing process to be sound."

In addition to commenting on the qualitative methodology and content of the report, several MCOs wished to address the lack of knowledge by some providers that became apparent during provider interviews.

Provider Knowledge Regarding Reimbursement

- "Providers stated they have concerns about reimbursement for non-invasive testing methods (e.g. urine or saliva). The code for testing is not dependent on the method so the reimbursement is the same whether it is a urine test or a blood test."

- "Some STD clinic providers seem to have misconceptions about reimbursement for STD related laboratory services and medications. These items are routinely covered when indicated. Current information on medications and a complete listing of all health plan formulary drugs is readily available to providers on (our MCO) website or by calling the company directly. Generically equivalent drugs are used when possible in place of more expensive brand name drugs."

Provider Knowledge Regarding ICSI Guidelines on Sexual Health Care

- "(Our MCO) is not surprised by the lack of knowledge among providers about the ICSI Guidelines. Through (our) medical record reviews of clinic charts, we have found that providers are not following ICSI Guidelines as they relate to routine testing. We will continue to educate providers about the ICSI Guidelines."

- "It is interesting that providers' experience with ICSI Guidelines around STD were limited. ICSI has at least six guidelines which mention either STD or infectious disease testing: Routine Prenatal Care, Domestic Violence, Preventive Services for Adults, Preventive Services for Children and Adolescents, Preterm Birth Prevention, and Preventive Counseling and Education. Perhaps the fact that there is no one ICSI Guideline that addresses only STDs or sexual health has caused confusion among providers. Clearly this subject is addressed by ICSI Guidelines."