Brief Sexual Histories and Routine HIV/STD Testing by Medical Providers

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Abstract

Clinicians who routinely take patient sexual histories have the opportunity to assess patient risk for sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV), and make appropriate recommendations for routine HIV/STD screenings. However, less than 40% of providers conduct sexual histories with patients, and many do not receive formal sexual history training in school. After partnering with a national professional organization of physicians, we trained 26 (US and US territory-based) practicing physicians (58% female; median age=48 years) regarding sexual history taking using both in-person and webinar methods. Trainings occurred during either a 6-h onsite or 2-h webinar session. We evaluated their post-training experiences integrating sexual histories during routine medical visits. We assessed use of sexual histories and routine HIV/STD screenings. All participating physicians reported improved sexual history taking and increases in documented sexual histories and routine HIV/STD screenings. Four themes emerged from the qualitative evaluations: (1) the need for more sexual history training; (2) the importance of providing a gender-neutral sexual history tool; (3) the existence of barriers to routine sexual histories/testing; and (4) unintended benefits for providers who were conducting routine sexual histories. These findings were used to develop a brief, gender-neutral sexual history tool for clinical use. This pilot evaluation demonstrates that providers were willing to utilize a sexual history tool in clinical practice in support of HIV/STD prevention efforts.

Introduction

APPROXIMATELY 20% OF THE 1.1 MILLION PERSONS living with HIV infection in the United States are unaware of their infection.¹ Blacks/African Americans are disproportionately affected among persons newly infected with HIV and those unaware of their infection, especially young black/African American men who have sex with men (MSM).^{2,3} Young black/African American MSM were the only group with significant increases in incident HIV infections from 2007 to 2010, despite data suggesting no differences in traditional, individual HIV risk behaviors (e.g., more sex partners, unprotected sex, more drug-associated sex) when compared with other racial/ethnic groups of MSM.^{2,4,5}

Routine HIV testing with linkage to care is a key strategy for early diagnosis, treatment, and reduction of ongoing HIV transmission. Yet rates of routine HIV testing among providers remain suboptimal (<40% of providers surveyed reported routine HIV testing with their patients),⁶ despite recommen-

dations that providers in health care settings perform routine HIV testing for patients aged 13–64 years⁷ or ages 15–65 years⁸ and that annual HIV testing occur for persons at high risk of acquiring HIV.^{7,8} Recent data suggest that more frequent HIV screenings every 3–6 months may be appropriate for some subgroups of young MSM who are at increased risk.⁴ More frequent screening may be especially important in the context of working toward the U.S. National HIV/AIDS Strategy (NHAS) goals of reducing HIV incidence, ensuring that HIV-infected persons have access to care and treatment, and reducing HIV-related health disparities.⁹

Some black/African American communities have a higher burden of sexually transmitted diseases (STD),¹⁰ including HIV, compared with other communities. Clinicians who provide care for blacks/African Americans, especially young men, have long been recognized as crucial partners for enhanced HIV and STD prevention efforts that raise awareness and increase routine HIV testing.^{11–13} Routine health care visits provide opportunities to offer HIV and STD counseling

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and testing for overall improved sexual health and HIV prevention. Yet, these opportunities are often missed by providers even for at-risk persons.^{14,15} Providers report several barriers to routine HIV screening with patients including costs, stigma, lack of time to address sexual health risks, lack of training and discomfort with conducting a sexual history, and lack of knowledge regarding HIV/STD screening reimbursements.^{16,17}

Routine sexual health discussions between patients and providers are a proactive strategy for increasing routine HIV and STD testing during medical visits, an important part of comprehensive quality patient care regardless of reason for the medical visit,^{18,19} and have been recommended by evidence-based guidance groups, including the U.S. Preventive Services Task Force,²⁰ and Centers for Disease Control and Prevention (CDC).¹⁰ Obtaining a comprehensive sexual history from patients allows healthcare providers to assess patients' behavioral risks, offer HIV/STD testing, and provide effective risk-reduction counseling.^{18,20,21} Still, routine sexual history taking is not a common practice among health care providers,^{19–21} and many physicians who report conducting sexual histories either do not document this information in the medical record or do not obtain adequate sexual health information.^{21–23}

Data suggest that racial/ethnic minority patients tend to choose physicians of similar racial/ethnic cultural backgrounds,²⁴ and that black/African American and Hispanic/Latino providers disproportionately serve and have an important role in many minority, historically underserved communities.²⁵ During 2006–2007, CDC led trainings with professional organizations, that included National Medical Association (NMA), to increase awareness about new revised recommendations to offer routine HIV screenings in health care settings. The mostly black/African American NMA physicians who participated suggested that brief sexual histories would increase their ability to bridge the dialogue to HIV/STD testing with their patients. In this report, we describe a collaboration with mostly black/African American NMA physicians who: (1) were trained to elicit a patient's sexual history and document pertinent findings using a sexual history tool, and (2) pilot tested the sexual history tool in their clinical settings with patients. We evaluated the numbers of documented sexual health discussions/use of the sexual history tool and completed HIV and STD screenings at baseline and post-training. We also incorporated physician feedback to refine and shorten the sexual history tool in a way that would meet the needs of busy clinical practices.

Methods

Study population

After release of the 2006 Revised Recommendations for HIV Testing for Adults and Adolescents in Healthcare Settings,⁷ the CDC collaborated with several professional organizations, including the NMA, to conduct educational trainings regarding the revised HIV testing recommendations.⁷ The NMA is the United States' largest professional organization of black/African American physicians, serving about 30,000 members. Trainings to conduct HIV screening were held with NMA providers at regional meetings and annual national conventions in 2007–2010 (~700 physicians reached), and sexual history trainings were subsequently held

with smaller groups of providers in 2010–2011. Evaluations and feedback forums followed these smaller, sexual history educational and training sessions to: (1) measure HIV testing awareness, (2) improve sexual history taking as a way to encourage dialogue about HIV and STD screening among physicians, and (3) develop and refine a brief sexual history tool using a previously validated, longer sexual history tool that could be used in busy clinical settings by primary care physicians, especially those who care for male patients. These sexual history trainings and pilot evaluations were designated as nonresearch (i.e., public health program implementation and evaluation), and protocols were reviewed and approved by both the NMA Executive Board and CDC.^{26,27}

Recruitment

NMA physician members were recruited in 2010–2011 to participate in the pilot sexual history training and implementation of the tool, and to provide evaluation feedback about the use of the sexual history tool in clinical practice (post-implementation). Physicians were eligible to participate if their medical practices were located in top 20 ranked cities based on high HIV and STD prevalence (2006 data), and if they reported serving a large number of black/African American male patients (based on general information provided by their clinical practice managers). These selection criteria were intended to ensure we collected data from physicians serving the highest risk group for HIV infection. NMA staff members led the recruitment effort with physician members by sending written and e-mail invitations describing the proposed sexual history training and evaluation study. NMA staff members also made follow-up phone calls at 2 and 4 weeks post initial contact. The convenience sample of providers was determined based on physicians who responded and agreed to participate.

Training

For the sexual history training component, a previously validated sexual history tool used by the California STD/HIV Prevention Training Center²⁸ provided the baseline sexual history questionnaire content. This four-page instrument was originally developed for use by clinicians as a guide to determine STD and HIV risk among MSM patients in California. For this study, NMA and CDC streamlined the tool to one page, based on early feedback from the NMA physicians during training sessions. The tool could be administered within 5–7 min and was intended for all male patients regardless of sexual orientation.

Trainings were guided by the theory of planned behavior, which suggests links between beliefs, attitudes, and behavioral intentions to effectively shift behavioral norms;²⁹ we thought this conceptual approach would be most appropriate to encourage a shift in the norm around sexual history taking by physicians. Physicians attended one of two sexual history trainings: either a single 6-h onsite session, or two 1-h interactive webinars. The trainings included background information about HIV/STD epidemiology, sexual history demonstrations, and physician-patient sexual history role-playing (onsite only). Physicians received continuing medical education (CME) credits for participating in the training sessions.

Evaluation and data analysis

Providers completed evaluation questionnaires at baseline (demographics and practice characteristics) and after the trainings. During the post-training implementation period (range=1–3 months), physicians administered the sexual history tool with patients during routine clinical visits. Physicians completed post-implementation program evaluation questionnaires and provided summary statistics regarding total HIV and STD tests performed and numbers of sexual histories documented in medical records at baseline and post-implementation. During 2010–2011, we conducted qualitative evaluations with NMA physician participants to learn about their experiences implementing the sexual history tool in clinical practice. We documented their recommendations to improve the sexual history tool for wider physician use.

Quantitative program evaluation. We used questionnaires to collect demographic information anonymously for participating physicians: age, gender, race/ethnicity, religious affiliation, medical training and specialty, patient demographics, and type of clinical practice and calculated frequencies. Questionnaires also assessed physicians' HIV/STD and sexual history-taking practices, including number of tests conducted and complete histories documented per month, types of medical practice, and demographics of patients they had seen for clinical visits. We compared differences in the mean numbers of baseline and post-training/post-implementation evaluations using *t*-tests. Data were analyzed using SPSS, version 20.0.0.

Qualitative program evaluation. The feedback forum included open-ended questions regarding: (1) physicians' baseline HIV testing and sexual history-taking practices and comfort level; (2) any changes in sexual history and HIV testing practices after sexual history training and implementation; (3) barriers and facilitators to routine sexual history tool utilization; and (4) recommendations for improving utilization of the sexual history tool. These group feedback forums were digitally recorded without identifiers. Audiotapes were transcribed verbatim. Data were then coded for common themes and subthemes using a general inductive approach, which included individual coding for themes by three authors (YL, TC, and MS), then grouping themes after discussion.³⁰

Results

Quantitative findings

Three hundred and fifty physician members were contacted with information about the sexual history training and evaluation study; most reported lack of time as the main reason they were unable to participate. Twenty-six physicians agreed to participate in the pilot sexual history training; 21 (81%) of 26 attended the onsite training, and 15 (58%) of 26 implemented the sexual history tool post-training (Table 1). Physicians who did not implement the sexual history tool (*n*=11) reported several reasons: a lack of administrative support (*n*=3), a change in clinical practice type (*n*=3), loss of job (*n*=2), and no reason reported (*n*=3). There were no significant demographic differences between physicians who participated and those who did not participate in implementation of the sexual history tool.

Trained physicians had medical practices located in the following cities: Atlanta, GA; Bethesda, MD; Bronx, NY; Chicago, IL; Dallas, TX; Detroit, MI; Los Angeles, CA; Miami, FL; New Orleans, LA; Philadelphia, PA; St. Thomas, U.S. Virgin Islands; and Washington DC. Twenty-four (92%) of 26 physicians provided baseline demographic and clinical practice information (Table 1): 58% were female, 88% self-identified as Christian, and ages ranged from 32 to 73 years (median 48 years). The median number of years of clinical practice was 13. The majority (79%) specialized in internal medicine or family medicine and 71% reported seeing 96 to 500 patients per month (median=300).

Almost all (96%) of the physicians reported providing some routine clinical services to young, black/African American MSM in their clinical practice (Table 1). Overall, statistically significant post-training increases were observed in the number of documented sexual histories taken and in HIV and STD tests ordered (Table 2). There was an increase in the percentages of physicians who conducted routine HIV tests, performed rectal gonorrhea cultures, conducted routine sexual histories with male patients, and documented sexual histories (Table 3).

Qualitative findings

Four major themes emerged from the analysis of the coded qualitative feedback and are described in detail below.

Clinicians needed more training and educational opportunities. Most physicians noted the need for increased sexual history training for a range of health care providers, including physicians, physician assistants, nurses, medical students, and clinical office staff. Physicians responded that opportunities for education and training in taking sexual histories were not included as part of their medical school or residency training, but should be routinely offered in medical schools and other training programs, through best practices videos and training by a seasoned provider. They suggested educational sessions to normalize sexual history taking and to make it a standard part of clinical practice would likely help decrease stigma and cultural barriers, especially with young black/African American MSM. They suggested that including role playing in sexual history trainings would help increase their comfort talking with patients about sex, so that stigma and homophobia could potentially also be decreased over time.

"It was not easy for me to do the sexual histories at first. I realized that I was not as prepared as I thought I was with asking more probing questions. If I have a new client or an elderly person, getting into an in-depth interview with them about their sexual history is hard, because some of them may view me as their grandson or like 'why is he asking that?'. And with the gay male patients, I realized that I had to check myself and examine my own ideas, especially if they are not comfortable talking with me. You know, so that I could serve my patients' needs." (male physician)

Providing a gender-neutral sexual history tool was important. After the NMA trainings, the providers expressed an understanding of the epidemiological data and of the importance of increasing efforts to take sexual histories routinely and to screen all patients for HIV/STDs, particularly

TABLE 1. DEMOGRAPHIC INFORMATION FOR PARTICIPATING NATIONAL MEDICAL ASSOCIATION (NMA) PHYSICIANS AND THEIR MEDICAL PRACTICES, 2010–2011

<i>Variables</i>	<i>Attended training N (%)^a</i>	<i>Attended training and implemented sexual history tool N (%)^b</i>
<i>Physician demographics</i>		
Training format:		
Onsite	21 (81)	10 (67)
Webinar	5 (19)	5 (33)
Gender		
Females	14 (58.3)	6 (46.2)
Males	10 (41.7)	7 (53.8)
Age		
30–39	4 (18.2)	3 (23.1)
40–49	7 (31.8)	5 (38.4)
50–59	7 (31.8)	3 (23.1)
60 and older	3 (18.2)	2 (15.4)
Hispanic/Latino ethnicity		
Yes	1 (4.5)	1 (8.3)
No	21 (95.5)	11 (91.7)
Religious denomination		
Christian	21 (87.5)	11 (84.6)
Islam	1 (4.2)	1 (7.7)
No religious affiliation	2 (8.3)	1 (7.7)
Number of years in practice		
1–9	7 (29.2)	5 (38.4)
10–19	7 (29.2)	4 (30.8)
20–29	8 (33.3)	4 (30.8)
30 and more	2 (8.3)	0 (0)
Medical specialty		
Family medicine	8 (34.8)	5 (41.9)
Internal medicine	10 (43.5)	6 (50.0)
Pediatrics/adolescent medicine	3 (13.0)	1 (8.3)
General surgery	2 (8.7)	0 (0)
<i>Practice demographics^c</i>		
Type of medical practice		
Private	17 (70.8)	12 (92.3)
Public	6 (25.0)	1 (7.7)
Military	1 (4.2)	0 (0)
<i>Patient demographics</i>		
Do you serve patients who are...?		
Alaskan Native	0 (0)	0 (0)
American Indian	4 (16.7)	2 (15.4)
Asian	10 (41.7)	6 (50.0)
Black/African American	22 (91.7)	12 (92.3)
Native Hawaiian/Pacific Islander	2 (8.3)	1 (7.6)
White/Caucasian	22 (91.7)	12 (92.3)
Hispanic/Latino	21 (87.5)	12 (92.3)
Do you serve patients who are...?		
Under 18	15 (62.5)	6 (46.1)
18–29	24 (100)	13 (100)
30–39	21 (87.5)	12 (92.3)
40–49	21 (87.5)	12 (92.3)
50–59	20 (83.3)	11 (84.6)
60 and older	20 (83.3)	11 (84.6)
Do you serve patients who are...?		
Heterosexual	24 (100)	13 (100)
Gay/MSM	23 (95.8)	12 (92.3)
Lesbian	22 (91.7)	12 (92.3)
Bisexual	14 (58.3)	7 (53.8)
Transgender	8 (33.3)	6 (46.1)

^aInformation available for 24 participants; 2 participants did not respond.^bInformation available for 13 participants; 2 did not respond.^cNumbers and percentages are reported only for physicians who responded “yes.”

TABLE 2. MONTHLY ESTIMATES OF HAVING ROUTINELY DOCUMENTED SEXUAL HISTORIES AND CONDUCTED HIV AND STD TESTING, NATIONAL MEDICAL ASSOCIATION (NMA) PHYSICIANS, 2010–2011

	Mean (baseline)	Mean (post-training follow-up)	Percent change	p Value
Mean number of documented sexual histories conducted per month	60	114	+90.0%	<0.0001
Mean number of HIV tests conducted per month	35	47	+33.0%	<0.01
Mean number of STD tests conducted per month	50	61	+21.0%	<0.02

black/African American males. They stated that the final sexual history tool would be more user-friendly for physicians if it could be administered to both male and female patients in any type of practice in 5 mins or less time; these aspects would limit stigma and the need for additional time during busy clinical visits. Physicians' feedback was used to create a streamlined, gender-neutral, final version of the sexual history tool with seven questions and that ended with triggers that encourage education and discussion about HIV and STD testing and prevention (Fig. 1).

"One of my concerns is not having enough information or things available. Now that you have the information from the sexual history tool, what are you going to do with it? And trying to spend the extra time trying to educate patients about behaviors that may be harmful is important. So maybe also giving us some triggers there to help educate about certain behaviors if they are present or make recommendations about condom use, etc." (female physician)

Several barriers exist for routine sexual history taking and HIV/STD testing. Several individual, community, and institutional-level barriers and challenges to routine implementation of the sexual history tool and HIV/STD testing were described by the physicians. At the individual level, barriers included some baseline lack of comfort in having detailed sexual history discussions with patients regardless of gender or sexual orientation, perceived lack of comfort among some patients, and intermittent office staff compliance with the new routine sexual history procedures. Community-level barriers included concerns about confidentiality and stigma; physicians reported that, while most patients seemed relieved to share their sexual history as part of their comprehensive

medical care, some were also concerned with the confidentiality of their sexual history information.

"...we have a very small population where everyone knows everyone. So I found that giving the receptionist the questionnaire to give to the clients and have them complete it and hand it back to her just wasn't going to happen, because they [patients] were not going to let the receptionist know their personal information. They [patients] don't have a problem answering the physician, but they were not going to have medical assistants or anyone else get that kind of sensitive information." (male physician)

Commonly cited institutional barriers included time constraints and concerns about reimbursement, especially when trying to justify routinely taking sexual histories and conducting HIV/STD testing efforts to health care administrators. Physicians noted that the limited time they had with patients, especially in managed care settings, made it difficult for them to both administer the sexual history tool and address patients' primary medical concerns, especially when sexual health concerns were not the primary reason for the medical visit. Despite the multiple barriers described, NMA physicians wanted to find solutions because of the impact of HIV and other STDs within many black/African American communities.

"There are just general time constraints that you have in a busy practice and trying to figure out how to introduce the sexual history tool to the patient is a challenge...but this epidemic in our communities is so important and the barriers are something that can be overcome." (male physician)

Unintended outcomes occurred for providers conducting routine sexual histories. Physicians reported several unintended benefits of implementing the sexual history tool. Many

TABLE 3. PERCENTAGE OF PARTICIPATING NATIONAL MEDICAL ASSOCIATION (NMA) PHYSICIANS CONDUCTING SEXUAL HISTORIES AND HIV/STD TESTING AT BASELINE (PRE-TRAINING) AND POST-TRAINING/ IMPLEMENTATION, 2010–2011

	Baseline	Post-implementation	Percent change	p Value
<i>Do you test for:</i>				
HIV and STDs (with symptoms reported)	100%	100%	—	
HIV routinely	50%	100%	+100%	<0.00001
Gonorrhea	92%	100%	+9%	0.03
Chlamydia	92%	100%	+9%	0.03
Syphilis	100%	100%	—	—
Hepatitis B	88%	90%	+2%	0.08
<i>Do you perform rectal gonorrhea cultures for men who report male sex partners?</i>	25%	50%	+100%	<0.001
<i>Do you conduct routine sexual histories with your male patients?</i>	75%	100%	+30%	0.02
<i>Are these sexual histories documented in the medical record?</i>	60%	92%	+48%	<0.005

Your doctor would like you to take a few minutes to ask you some direct questions about your sexual health. These questions are personal, but will help your doctor keep you healthy. We ask these questions of all patients regardless of their age or marital status. This information is just as important to discuss as information about your physical and mental health. Like the medical history you provide, this information is strictly confidential. Please check all boxes that are appropriate.

- Do you have sex with ☐ men, ☐ women or ☐ both?
- Have you had any sex in the past 12 months? ☐ Yes ☐ No
Any sex includes **oral sex**, where someone's mouth goes on someone's vagina or penis or anus; **anal sex**, where someone's penis goes into an anus; or **vaginal sex**, where someone's penis goes into a vagina?
- In the *past 12 months*, how many partners have you had sex with? _____
- Do you or your partner use condoms for any of the types of sex described above?
☐ Yes If yes, which ones, ☐ oral, ☐ vaginal or ☐ anal?
☐ No
- Have you ever been tested or treated for any sexually transmitted diseases (STDs), including chlamydia, gonorrhea, syphilis, herpes, or HIV?
☐ Yes If yes, which ones, ☐ chlamydia, ☐ gonorrhea, ☐ syphilis, ☐ herpes, ☐ HIV
☐ No
- We recommend routine HIV and some STD testing as part of regular medical visits. Would you like to be tested for HIV, gonorrhea, chlamydia or syphilis today? ☐ Yes ☐ No If no, reason why:

- Before you leave today, we'd like to provide you with important information that can help you protect yourself from sexually transmitted diseases, including HIV. Please check the topics that most interest you. (Check all that apply)
☐ Condom Use ☐ Birth control ☐ Discussions with sex partners ☐ Regular check-ups ☐ Abstinence
☐ Other (specify) _____

If you have any questions about this form or sexual history, please ask the doctor when you meet today. Thank you.

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FIG. 1. Brief Sexual History Tool, developed by participating National Medical Association (NMA) physicians, 2010–2011

stated that the tool helped them improve the quality of care they were able to deliver to both men and women. They also reported the tool improved patient–provider communication by allowing both physicians and patients to discuss topics related to sexual health that were sometimes viewed as “taboo,” or otherwise stigmatized, such as same-sex encounters or teenage sexual activity. One provider commented that implementing the tool fostered discussions with patients on topics, “which may not have otherwise been addressed.” Importantly, the tools also provided physicians with the op-

portunity to counsel patients about safer sexual practices and to offer routine HIV and STD testing.

“Using this tool really broke down barriers between my patients and me and gave us a green light to talk about things that had not previously been discussed. One of my patients was actually smiling with excitement that I raised the topic of sex!” (male physician)

“But the tool did teach me a lot more about myself and I think it broke down barriers that I didn’t know were there between patients and myself. So as you peel back the onion

layers, it just makes for a better physician-patient relationship, I think.” (female physician)

Discussion

Lessons learned

To increase routine sexual history taking and HIV/STD screening during clinical visits, we worked with front-line clinical providers to develop a brief user-friendly tool that can be used with patients in a variety of practice settings. Despite reported individual and institutional barriers to these routine sexual history activities, we found that participating physicians felt strongly about working toward HIV/STD prevention solutions, and demonstrated the capacity and willingness to utilize new sexual history strategies. This is the first evaluation report of a provider-developed brief sexual history tool that is user-friendly and able to be completed quickly in the context of a routine medical visit.

During the evaluation, providers described that individual-level barriers, such as stigma and physician and patient comfort with discussions of same-sex behaviors,^{31–33} could be decreased by more wide-spread implementation of a brief, routine sexual history tool. Additional clinical activities, such as training medical personnel to take sexual histories routinely during clinical visits, could have a significant impact on the ability of providers to positively dialogue with patients about HIV and STDs and offer screening tests.³⁴ Creating clinical performance indicators to track routine sexual history taking and HIV/STD measures could also help remind providers and facilitate routine sexual health dialogues with patients. Also, sexual history trainings and conducting brief sexual histories can be strengthened as part of medical and nursing school training, so that providers feel more prepared when they are in clinical practice full-time.

Translation to program

This pilot program evaluation supported the development of two products to help facilitate sexual history taking and HIV/STD screening as part of routine clinical care: (1) a seven-item brief sexual history tool available in both English (Fig. 1) and Spanish from the NMA, and (2) an online Sexual History Video Training Activity available at the NMA website (<http://nma.broadcastmed.net/hiv/hiv-and-routine-healthcare-provider-sexual-history-taking-among-physicians-missed-opportunities-in-primary-care>). The sexual history tool can also be adapted for use in resource-limited settings for paper or electronic completion by patients during clinical visits. For NMA providers who expressed concerns about institutional barriers and ensuring services provided were reimbursable, we provided an ICD-9 reference list that could be used to bill for sexual history-related activities (developed by the American Medical Association and the American Academy of HIV Medicine) and that is available at: (http://www.aahivm.org/Upload_Module/upload/Provider%20Resources/AAHIVM%20CPT%20Coding%20Guide.pdf).

Limitations

Our study has some limitations. This was a small pilot evaluation, which would be strengthened by a follow-up study with a larger and more diverse sample. Additional program research and evaluations with providers and patients are war-

ranted. Additionally, the data for this report were drawn from a small convenience sample of black/African American physicians who were members of a professional organization (NMA). These data may not be generalizable to non-NMA physician members who also provide care to communities disproportionately affected by HIV/STDs. Still, these data underscore the need for improved sexual history training, documentation, and dialogue in health care settings and the importance of this dialogue as a bridge to HIV/STD screenings, particularly for disproportionately affected young MSM of color.

In conclusion, social and structural complexities and barriers that contribute to the domestic HIV epidemic and include community sexual networks with higher prevalence of disease,³⁵ warrant prevention approaches that include increased, routine provider-based sexual history trainings as part of clinical intervention strategies. Interventions that engage health care providers who serve persons at disproportionate risk of exposure to HIV/STDs are especially needed. Such interventions can more effectively strengthen sexual health dialogue and increase routine HIV/STD screenings as we work collectively toward domestic HIV/STD prevention goals and decreased HIV-related racial/ethnic disparities.

Acknowledgments

We thank all of the participating NMA physicians for their time and contributions to this evaluation and to national HIV/STD prevention efforts. We also thank Drs. Gregory Pappas, Kimberley Jeffries-Leonard, Caryn Walker, and Leigh Willis for their technical feedback and guidance and Mrs. Karen Woods for her epidemiologic research assistance.

This activity was funded in part by CDC funding opportunity announcement #PS06-612; Grant Number 5U22PS000553.

Disclaimer: The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

Author Disclosure Statement

No competing financial interests exist for this study. Dr. Jordan has previously collaborated with Abbott, Bristol Myers Squibb, Gilead, Glaxo Smith Kline, Pfizer, Roche, Serono, and Tribotec, None of which funded this study.

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