A Qualitative Investigation of Healthcare Engagement Among Young Adult Gay Men in New York City: A P18 Cohort Substudy

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Abstract

Purpose: We used in-depth interviews with a cohort of young adult gay men (YAGM) to provide a more detailed understanding of their current healthcare engagement, including experiences with the healthcare system, provider knowledge of healthcare needs, and desired provider characteristics.

Methods: Qualitative interviews were conducted with a sample of 40 YAGM in New York City. The interview guide examined healthcare engagement across key developmental stages: childhood (birth-12), adolescence (13-18), young adulthood (19-22), and the present (23-26). All transcripts were coded using a consensual qualitative research approach to identify crosscutting topics. The interviews were conducted between September and October 2015.

Results: The following topics were identified: experiences with the healthcare system, provider knowledge of healthcare needs, and desired provider characteristics. Common barriers to healthcare access were financial concerns, lack of insurance, and dissatisfaction with the care provided. Reasons for dissatisfaction with care were based on perceptions of providers' anti-gay attitudes, judgment of same-sex sexual behavior, and lack of provider knowledge about YAGM's health needs. This often led men in this study to seek sexual healthcare from providers other than their primary care provider. When asked about desired provider characteristics, participants noted that basic demographics were of less importance than skills-based characteristics such as rapport, comfort discussing sexual health issues, and knowledge of YAGM's health.

Conclusion: YAGM have unique challenges to engaging in healthcare, including provider stigma and lack of provider knowledge of YAGM's health needs, which are not faced by other young adult populations. The results from this study highlight the need for more extensive and standardized training in medical school and as part of continuing medical education for healthcare providers.

Keywords: barriers, facilitators, gay men, healthcare engagement, provider characteristics

Introduction

HEALTHCARE ENGAGEMENT IN THE United States is limited due to myriad factors including lack of insurance,^{1,2} co-pay costs,³ time constraints,⁴ and proximity to healthcare facilities.^{5,6} Young adults between the ages of 18 and 25 face additional barriers to healthcare engagement related to changing providers,⁴ navigating the healthcare system,⁷ and keeping healthcare services private from family members.⁸⁻¹⁰ Men who engage in same-sex sexual behaviors have some of the lowest rates of healthcare engagement,¹¹⁻¹³

as discomfort in discussing sexual behaviors^{14,15} and lack of provider knowledge about their healthcare needs¹⁶ further complicate their experience with the healthcare system.

Even when men who engage in same-sex sexual behaviors are engaged in healthcare, they may not receive all the services they need. Receipt of incomplete healthcare services is often related to the nonprioritization of healthcare,^{8,17,18} assumptions of heteronormative behavior,¹⁹⁻²¹ experiences of anti-gay attitudes,²² and limited provider knowledge about the healthcare needs of men who engage in same-sex sexual behaviors.^{20,23} Experiences of anti-gay attitudes in

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the healthcare setting are associated with nondisclosure of sexual orientation and behaviors.²² A further consequence of nondisclosure is healthcare fragmentation, whereby men who engage in same-sex sexual behaviors separate their sexual health services from primary care and engage in sexual health services from a healthcare setting that is separate from their usual source of care—often LGBT health or sexually transmitted infection (STI) testing centers.²

Healthcare engagement is also determined by the patient's ability to find providers who have desired characteristics.²⁴ Previous studies of desired provider characteristics indicate that gender and sexual orientation are important considerations when selecting a provider^{8,25} as are positive patient-provider interactions.^{20,24} Some studies indicate that rapport and nonjudgmental interactions with providers may be the most important characteristics for selecting a provider.¹⁴ In addition, young adult men who engage in same-sex sexual behaviors seek providers who have appropriate knowledge of specific healthcare needs of this population.²³

In the United States, young adult men who engage in same-sex sexual behaviors have a disproportionate burden of STIs and HIV,^{26–28} and mental health issues,²⁹ specifically depression,^{26,30} anxiety,^{26,31} and suicidal ideation,^{26,32} as well as intimate partner violence^{26,33} and substance use.^{26,34} These disparities in health outcomes are related to lower rates of healthcare engagement,^{11–13} receipt of incomplete healthcare services,² and lack of provider knowledge about the healthcare needs of men who engage in same-sex sexual behaviors.^{20,23} Although there are numerous quantitative studies of healthcare engagement of young adult gay men (YAGM), this study fills an important gap in the literature by investigating healthcare engagement among YAGM qualitatively. Furthermore, this study adds to the extant literature by describing the experiences of YAGM in the United States after the implementation of the Affordable Care Act.

Methods

Sample

The qualitative part of the healthcare access study involves a purposive sample of 40 participants drawn from the on-going P18 Cohort Study. Briefly, participants in the P18 Cohort Study were recruited between June 2009 and May 2011 through both community outreach methods (i.e., flyers and internet advertisements) as well as venue-based methods (i.e., recruitment at community centers, bars, and clubs). To be eligible for the cohort study, potential participants had to report (1) being assigned male at birth, (2) being 18 or 19 years old at the time of screening, (3) having had a same-sex sexual encounter in the six months preceding screening, (4) residing in the New York City metropolitan area, and (5) an HIV-negative serostatus.³⁵

Procedures

All participants actively engaged in the P18 Cohort Study between August and September 2015 received an email about the healthcare access study and were asked to contact study staff if they were interested in participating in this qualitative part of the study. During the screening process, individuals were also asked questions about health insurance status, types of providers seen, and frequency of healthcare

visits, specifically visits to a usual source of care, emergency room, dentist, and mental healthcare provider. Participants were eligible for the qualitative healthcare access study if they (1) were currently enrolled in the P18 Cohort Study, (2) identified as male, (3) identified as gay, (4) reported an HIV-negative status, (5) lived in the New York City metro area, and (6) had only lived in the United States during the past five years. This sample was limited to gay men only as sexual orientation, sexual behaviors, and gender identity of an individual's partner affect healthcare needs and counseling.²⁶ Including gay, bisexual, and trans-identified participants in the qualitative study would not allow the research team to reach saturation of qualitative data that are required to identify emerging topics.

If the participant was eligible, they were scheduled for a semistructured interview that lasted between 45 and 90 minutes. Before the interview, staff reviewed the consent form with the participants. Participants could skip questions or refuse to answer questions without penalty. Written consent was obtained for each participant. Participants received \$30 for their time. Interviews occurred between September and October 2015. The New York University Committee on Activities Involving Human Subjects (UCAIHS) approved the study protocol (IRB Number 10-6802).

Domains

The theoretical basis for this study is Andersen's Behavioral Model of Health Services Use, specifically the construct that examines characteristics of the population at risk, which includes the predisposing, enabling, and need factors that determine healthcare engagement.³⁶ Following this model, the interview guide sought to gather data on predisposing characteristics of the population at risk and consumer satisfaction that examined each participant's engagement with the healthcare system across four key developmental stages: childhood (birth–12), adolescence (13–18), young adulthood (19–22), and the present (23–26). The following prompts were used for each developmental stage: *Tell me about your health? What was it like going to the doctor? What was your family's attitude about healthcare and going to the doctor? What was your attitude about healthcare and going to the doctor?* Participants were also asked to reflect on how their sexual orientation and behaviors affected care, and how aware their doctors were of the healthcare needs of gay men, how important it is for them to be able to see a doctor, and about desired provider characteristics.

Analytic plan

All interviews were audio recorded and transcribed by a transcription service. As the interview guide was developed within Andersen's Behavioral Model of Health Services Use, the analysis follows a framework analysis of the qualitative interviews.^{37,38} Four members of the 10-person study team randomly selected eight transcripts to identify emergent codes across the interviews. This process resulted in a coding scheme that could be used by the 10-member coding team. Each interview was coded in ATLAS.ti (ATLAS.ti Scientific Software Development GmbH, Berlin, Germany) and reviewed by two members of the research team for consistency of codes. Discrepancies in the initial coding were reconciled by using a consensual qualitative research (CQR)

approach that relies on reviewers discussing the codes until consensus is reached.³⁹ Once transcripts were coded and reconciled, the first author identified crosscutting topics that emerged across all interviews. Participant responses that were coded under these topics were extracted for further analysis. It is important to note that all characterizations and attributes of the providers mentioned in the results are based on the perceptions of the participants. The research staff did not verify these perceptions against the actual provider attributes.

Results

Sample characteristics

Table 1 provides a summary of the participant demographics. The mean age of the sample was 23.34 years (SD=0.75). Participants in this study reported their race and ethnicity as follows: 30.0% ($n=12$) Hispanic/Latino, 30.0% ($n=12$) Black non-Hispanic, 20.0% ($n=8$) White non-Hispanic, 17.5% ($n=7$) Asian/Pacific Islander, and 2.5% ($n=1$) as multirace. Sixty five percent ($n=26$) of the sample identified as low/lower middle/middle income. Ninety percent ($n=36$) had health insurance, 7.5% ($n=3$) were uninsured, and 2.5% ($n=1$) were unsure if they had health insurance. In terms of employment status, 37.5% ($n=15$) of the sample were working full time, 37.5% ($n=15$) were working part time, and 25.0% ($n=10$) were not currently employed.

Table 2 provides a summary of information on participants' current healthcare engagement that was collected as part of the screening process. Participants were asked how many healthcare visits they made to their usual source of care in the past 12 months. Of the 40 participants, 12.5% ($n=5$) did not have a visit, 20.0% ($n=8$) had one visit,

TABLE 2. CURRENT HEALTHCARE ENGAGEMENT OF A SAMPLE OF YOUNG ADULT GAY MEN, NEW YORK CITY, 2015 ($N=40$)

Healthcare visits	%	n = 40
Usual source of care visits		
0 visits	12.5	5
1 visit	20.0	8
2 to 5 visits	55.0	22
6+ visits	12.5	5
Emergency room visits		
0 visits	70.0	28
1 visit	15.0	6
2+ visits	15.0	6
Dental visits		
0 visits	30.0	12
1 visit	47.5	19
2+ visits	22.5	9
Mental health visits		
0 visits	67.5	27
1 to 11 visits	20.0	8
12+ visits	12.5	5

55.0% ($n=22$) had two to five visits, and 12.5% ($n=5$) had six or more visits. In addition, 30.0% ($n=12$) had a visit to the emergency room in the previous 12 months. Seventy percent ($n=28$) of participants had a dental visit in the previous 12 months and 32.5% ($n=13$) had a mental health visit in the previous 12 months.

Qualitative analysis

During the interviews, three major topics emerged: experiences with the healthcare system (249 quotes from 32 participants), provider knowledge of healthcare needs (112 quotes from 31 participants), and desired provider characteristics (286 quotes from 32 participants).

Experiences with the healthcare system

Participants indicated that some of the same factors that led to negative perceptions of the healthcare system also acted as barriers to engaging in healthcare (i.e., lack of insurance and cost of healthcare). One participant shared that although being healthy was important, this could be achieved without the healthcare system.

Being healthy is a priority, but in terms of visiting healthcare facilities, I think not having insurance and stuff growing up, it wasn't a first resource so it's something I learned to live without. (Male, 24, Black non-Hispanic)

In addition to these factors, participants said that lack of motivation also led to the decision to forgo healthcare. Furthermore, even though they were more willing to discuss their sexuality and sexual behavior with providers, these interactions were not always supportive. Participants shared examples of provider judgment of same-sex sexual behaviors and anti-gay attitudes.

The doctor that I had was more of like a family doctor... She wasn't knowledgeable with the LGBT community... She's

TABLE 1. SOCIODEMOGRAPHIC CHARACTERISTICS OF A SAMPLE OF YOUNG ADULT GAY MEN, NEW YORK CITY, 2015 ($N=40$)

Sociodemographic characteristics	%	n = 40
Age (M=23.34, SD=0.75)		
22	10.0	4
23	40.0	16
24	45.0	18
25	5.0	2
Race/ethnicity		
Hispanic	30.0	12
Black non-Hispanic	30.0	12
White non-Hispanic	20.0	8
Asian/Pacific Islander	17.5	7
Multirace	2.5	1
Socioeconomic status		
Low, lower middle, middle	65.0	26
Upper middle, upper	35.0	14
Insurance status		
Insured	90.0	36
Uninsured	7.5	3
Unsure	2.5	1
Employment status		
Working full time	37.5	15
Working part time	37.5	15
Not currently employed	25.0	10

never really had gay patients so for her it's kinda new and her reaction was kinda like oh, you know, and you're young, right now you shouldn't be having anal sex... It wasn't the reaction that I was expecting. I was expecting more empathy or understanding or at least a little bit of more guidance as opposed to don't do that. (Male, 22, Hispanic)

Participants in the study discussed greater levels of comfort with going to the doctor because they were more comfortable with themselves and their sexuality. This increased comfort was often associated with young adulthood (ages 19–22) when participants were leaving home for the first time. Not only did evolving identity lead to increased levels of healthcare engagement but participants also noted that transitioning to young adulthood and establishing their lives separate from their parents have led to a greater sense of freedom when seeking health services.

At 18, I was more open. I was able to sit there in private with my doctor and tell her this is what's going on in my life, this is who I am, this is what I do and I kind of felt a sense of relief to be able to talk to my doctor finally about my life and the activities that I do... surprisingly, I didn't receive the [negative] feedback that I was expecting. (Male, 22, Hispanic)

However, not all men in this study were comfortable disclosing their sexual orientation and behaviors. For some men in this study, previous experiences of anti-gay attitudes have led to more selective disclosure of sexual orientation and behaviors.

Well, certainly I've been more weary of it, and more—I choose more delicately what I say and to whom I say it to. (Male, 23, White non-Hispanic)

Racial and ethnic minority men in this study also indicated that they experience multiple minority burdens and choose to cover to avoid disclosure of sexual orientation.

He's [the doctor] a Muslim... So his thing is he doesn't wanna hear too much about sex with guys on guys. So it really makes it really uncomfortable to talk about it because all I'm gonna get is "Marry a girl"... It just comes up all the time because he knows I am gay. (Male, 24, Black non-Hispanic)

Provider knowledge of healthcare needs

Participants in the study were asked about their health-seeking behaviors, including types of providers seen and where they sought primary care and sexual health services. Participants said they regularly sought sexual healthcare services; however, a healthcare provider was not always administering these services.

I've always gotten knowledge of gay men health and about risk and HIV and stuff through outside sources... I don't separate it because I feel any type of way, I feel uncomfortable speaking to my doctor. This is just how it is, I go for my asthma attacks and I don't go for if I need a condom you know what I mean. It's just it's different. But I wouldn't mind my doctor educating me and speaking to me about it. (Male, 23, Black non-Hispanic)

For some participants, health information provided in non-healthcare settings has improved their knowledge of appropriate services for YAGM and has led them to change providers.

I actually got an anal pap smear or whatever you call it there the other day. Because the guy who runs [service organization] was just telling some of the guys in this gay men's group about the services they offered. And I realized that I don't think my doctor offers that. (Male, 24, Hispanic)

Participants opted to seek information about sexual health services from LGBT centers because doctors were more knowledgeable about YAGM's health needs.

When I visited the gay center then they taught me a whole new vocabulary and certain different aspects of myself that I should pay attention to more, which helped me out. (Male, 23, Asian/Pacific Islander)

Desired provider characteristics

Participants were asked to describe their ideal healthcare provider both in terms of demographics (i.e., gender, race/ethnicity, and sexual orientation) and skills-based characteristics. Participants prioritized skills-based characteristics over demographic characteristics.

I genuinely look for a doctor to be open-minded, of course, and not judgmental... (Male, 24, Black non-Hispanic)

Although no trend emerged for demographic preferences for providers, racial and ethnic minority participants discussed a preference for providers who had a marginalized identity.

Well, ideally I'd want someone who's of a marginalized identity so at some point anytime I could say if I were experienced in something because of my identities, for example, they would sort of understand at least. (Male, 25, Asian/Pacific Islander)

Participants expressed that they wanted their providers to have more skills-based characteristics and indicated they are looking for a provider who is knowledgeable about YAGM's health issues.

I definitely could've used a doctor to talk to like a—yeah, a doctor to talk to just about what's healthy, and what's not with gay sex. Like, what is actually unhealthy—there's so much online that you read and stuff, and just to say, "Is this actual safe practice" like, safe health practices. Like, "What's okay? What's not? What shouldn't be happening?" like, basic gay sex ed. (Male, 23, multirace)

Participants also said they were looking for providers who were comfortable discussing sexual health issues, open minded, and empathetic. Participants in the study also indicated that they wanted greater rapport with their provider and a sense that the provider keeps up with their patient's needs.

I think of a doctor as somebody who's very nonjudgmental and you feel comfortable and safe with to talk to about. I think, also, a doctor who's knowledgeable and who, if he didn't know something, he'd admit that before pretending that he did. I think that's important. A doctor whose well informed of current events and is very—who keeps up with his patients, their health activities, and who is personally invested in his work. That is ideal to me. (Male, 24, Black non-Hispanic)

First, perceptions of the healthcare system affected engagement in healthcare for YAGM. Healthcare engagement

among this sample varied greatly both in type of providers seen and frequency of visits. Second, lack of provider knowledge of the healthcare needs of YAGM altered their pattern of healthcare engagement. Overall, YAGM in this population indicated a lack of healthcare coordination because primary care providers are not aware of the healthcare needs of this population. Third, participants in this study did not express a consistent desire for providers based on demographic characteristics; however, they emphasized overwhelmingly the importance of skills-based characteristics.

Discussion

This study provides several insights into healthcare engagement among YAGM. Despite the fact that the interview protocol asked about engagement in general healthcare, participants spoke almost exclusively about sexual healthcare services. Participants said that the cost of healthcare services was a barrier to healthcare. While the implementation of the Affordable Care Act extended dependent health insurance coverage until age 26,⁴⁰ some of the participants may not be able to utilize these benefits because their parents do not have insurance or not all insurance companies will provide health services if the dependent lives in a different state than their parents. Deductible costs and co-pays are a larger percentage of a young adult's income than an adult's income.^{3,41}

Examining the Andersen construct³⁶ of consumer satisfaction, this study revealed distinct health-seeking patterns for men in this study. Some men in this study chose to separate sexual healthcare from primary care services. For some participants, the decision to separate sexual healthcare and primary care services was related to perceived provider-based discrimination or the provider's limited knowledge of YAGM's health needs. Participants who separated services based on negative experiences with providers often sought services at LGBT health centers. Providers in this healthcare setting tend to have more desired characteristics, including providing appropriate care for YAGM in a nonjudgmental and culturally competent manner.²⁴

YAGM's unsatisfactory experiences in the receipt of primary care may encourage the substandard healthcare practice of fragmenting primary care and sexual healthcare among this population.² This separation of healthcare seeking may create a hierarchy of healthcare needs in which sexual health screening is prioritized over routine preventive care. This means that an individual may not receive comprehensive healthcare because this hierarchy interrupts the coordination of care. Seeking frequent care for sexual health needs only may give an individual a false sense that they are taking complete care of their health.² In reality, YAGM who separate their healthcare services may be missing important opportunities for early diagnosis of nonsexual health issues such as cancer,^{26,42} and mental health needs.^{26,30,32}

Men in this study indicated a lack of healthcare coordination. Barriers to coordinated care were perceived provider bias and lack of provider knowledge of YAGM's health needs. Similar to one previous study, the men in this study did not have a preference for providers of a specific gender or sexual orientation.²³ Participants said they wanted providers who had skills-based characteristics such as knowledge of YAGM's health needs and good rapport with patients. A recent study found that having staff who were knowledgeable

about the healthcare needs of men who have sex with men increased the use of sexual health services in a primary care setting.⁴³ As mentioned previously, the reported experiences of providers' anti-gay attitudes are based on the perceptions of the participants and may not represent the actual provider attitudes. Nevertheless, the perception of providers' anti-gay attitudes may drive the fragmentation of primary care and sexual health services and suggests the need for easily identifiable LGBT-friendly providers outside of traditional sexual healthcare facilities.

The findings from this study should be used to inform clinical practice. Healthcare facilities that provide LGBT services should work to advertise these services and competencies more widely. Websites can include the Pride and gender identity flags as a signal that their facility is LGBT friendly. In addition to symbols, adding search filters that include options for LGBT health will help connect patients to services. Finally, medical providers should consider listing themselves with publicly available LGBT-friendly provider directories, including GLMA: Health Professionals Advancing LGBT Equality's Provider Directory (national listing), Columbia University's LGBT Health Initiative (NYC-specific listing), the NYC Department of Health and Mental Hygiene's NYC Health Map (NYC-specific listing), or similar directories that exist in other geographic locations. Creating and maintaining public listings of LGBT-friendly services help to change the culture of the healthcare system and reduce barriers to finding LGBT-competent care.

In addition to facility identification strategies, patient forms should be updated with more inclusive language that asks about gender identity and sexual orientation. Inclusive language on patient forms creates a more comfortable environment for both patients and providers and may facilitate disclosure of sexual orientation and behaviors to providers.²¹ Asking about sexual orientation and the gender of sexual partners also acts as an external cue to patients who might not be aware that disclosure of this information is relevant to the provision of healthcare services.^{20,44} Furthermore, providers should seek additional training and/or resources to help them take sexual histories that are respectful and inclusive of all sexual orientations and gender identities. The Centers for Disease Control and Prevention have issued a guide about taking sexual histories that encourages providers to ask about the Five Ps: Partners, Practices, Protection from STIs, Past History of STIs, and Prevention of Pregnancies.⁴⁵ Following this guidance may help to elicit sexual health information from the patient, which will help providers identify relevant screenings and physical examinations. Incorporating this guidance in all healthcare settings, including primary care, and not just in LGBT centers has the potential to positively impact the perception of the healthcare system among YAGM. Improved sexual history taking creates more personal conversations, thereby improving patient and provider relationships.^{25,46,47}

Findings from this study may also help to inform future studies. Future quantitative studies should ask about patient satisfaction with provider's knowledge of LGBT health needs, coordination of sexual healthcare and primary care, or intentional fragmentation of healthcare services. For patients engaged in healthcare, future studies should ask how patients find providers, about the presence of language on patient forms, and if patients disclosed their sexual orientation to the provider.

Limitations

This study is not without limitations. First, this study recruited participants from a sample of YAGM already involved in a study of health and healthcare issues. As the pool of participants is already engaged in health research, participant experiences may not reflect the experiences of a nonresearch-engaged population. Second, the P18 Cohort Study provides STI and HIV testing at every visit and this may be considered a source of sexual healthcare. As the P18 Cohort Study asks questions about sexual risk, participants may be more likely to report their sexual healthcare needs than general healthcare needs. Third, this study is conducted in NYC where there are many free or low-cost healthcare options provided by nonprofit organizations, public hospitals, and Department of Health-sponsored clinics. In addition to the numerous types of healthcare facilities, the existence of specific healthcare clinics that serve the LGBT population may contribute to the relative ease of finding comprehensive healthcare services. Given these limitations, the findings may not be generalizable to other populations. Despite these limitations, this study contributes to the limited qualitative literature on the healthcare engagement of YAGM and the findings may be used to inform survey development for quantitative surveys of healthcare engagement among this population.

Conclusion

This study examined the healthcare experiences of YAGM living in NYC. These participant interviews add a necessary personal context to quantitative studies of healthcare engagement and engagement among YAGM. This study shows that even when YAGM are engaged in routine healthcare, not all of their healthcare needs are met. Lack of provider awareness of the healthcare needs of gay men led the participants in this study to seek healthcare information from sources other than their primary care provider, such as LGBT service providers. Seeking health information from sources other than their primary care provider creates a pattern of health-seeking behavior which means that no one provider has a comprehensive understanding of their patient's healthcare needs. Healthy People 2020 emphasizes the coordination of sexual healthcare and primary care as the best way to address an individual's holistic healthcare needs.⁴⁸ One way to change the pattern of fragmented healthcare is for providers to build rapport with their patients; however, to do this, providers need to ask their patients about their sexual behaviors and partners in an open and respectful environment instead of assuming that their patients are heterosexual. In addition, providers should be trained on the specific healthcare needs of their YAGM patients. Improved patient and provider communication as well as specific trainings have the potential to change YAGM's perceptions of the healthcare system.

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