Protecting, maintaining and improving the health of all Minnesotans

A Health Care Needs Assessment for Men Who Have Sex With Men (MSM) finds MSM to be affected by a number of "care gaps" with causes both varied and complex.

The needs assessment was completed April, 2008, by a team of nine second-year medical students from the University of Minnesota with the assistance of the Syphilis Elimination Coordinator from the STD and HIV Section of the Minnesota Department of Health. It is the result of an extensive literature review, interviews with key informants, and focus groups of MSM health care consumers. The report describes health care gaps for MSM, examines the causes of and previous attempts to close these gaps, makes recommendations to improve health outcomes, and offers a plan for continued evaluation.

Areas of concern identified were:

- Violence – including hate crimes and domestic abuse
- Mental health
- Substance abuse
- Insurance coverage
- Sexual health risk assessment, screening, prevention and treatment
- Complete care of a patient by a primary care provider

Causes identified include institutional barriers such as insurance gaps and accessibility, lack of culturally appropriate programming in certain areas, a lack of cultural competency among many health care providers, and an unwelcoming environment for MSM in some clinics.

As a result, the report makes extensive recommendations in several areas of health care delivery. Recommendations include:

- *Clinics:* Train all staff, from front-line staff to laboratory personnel, in sensitivity, empathy, the appropriate use of language and important gay, lesbian, bisexual, and transgender (GLBT) health issues.
- *Health care providers:* Regularly incorporate sexual health risk assessment, screening and prevention discussions in routine health maintenance visits with GBLT people.
- *Health care consumers:* Become educated on sexual health risks and request screening tests from health care providers.
- *Public policy:* Increase research to examine and reduce barriers to appropriate sexual health risk assessment, screening and prevention.
- *Community-based programs:* GLBT people should be included in substance abuse program planning in a culturally competent manner.

The report concludes, "…we hope that issues surrounding MSM health care needs will finally be recognized and addressed in the clinical setting."

Additional copies of this report are available at the STD and HIV Section Web site at www.health.state.mn.us/sep, or by phone at 651-201-4004.

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A project of the University of Minnesota Medical School,

Physician and Society II: Health Improvement Project

completed for the Minnesota Department of Health, STD/HIV Section

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I. Executive Summary

This Health Improvement Project is a health care needs assessment for men who have sex with men (MSM), completed for the Minnesota Department of Health, STD/HIV Section. It identifies six issues contributing to a "care gap" in the health care of the MSM population, considers the origins of the disparity, discusses barriers to improving care, and proposes action at multiple levels to overcome theses barriers, reduce disparity, and improve health outcomes.

Methods

The needs assessment began with a review of pertinent literature. We then crafted two questionnaires that could be used to perform structured interviews (see Appendices A and B). The first questionnaire is for experts in the field of MSM health, including health care providers and community organizers. The second questionnaire is for health care consumers who self-identify as MSM.

Our contact at the Department of Health put us in touch with many providers and community organizations. We administered the "expert" questionnaire during a meeting with the staff at Allina Medical Clinic in Uptown, as well as in personal interviews with Dr. Meininger of the Rainbow Health Initiative, Dr. Bucher – a family physician, and Micah Ludeke – a provider (and board member) for the MN Transgender Health Coalition. We also attended a Positive Link event at Pillsbury House and the Pride Alive "Tuesday Nighters" group to assess consumer perspective.

Conclusions

Drawing on the literature and our field work, we identified six issues contributing to a "care gap" in the health care of the MSM population:

(1) violence – including hate crimes and domestic abuse

(2) mental health

(3) substance abuse

(4) insurance coverage

(5) sexual health risk assessment, screening, prevention and treatment

(6) complete care of a patient by a primary care provider

Recommendations

Our full list of recommendations calls for action at multiple levels of the health care system and is beyond the scope of this summary. However, our two main recommendation groupings are informed by the theme of education.

Sensitivity training for clinic personnel and providers will help a clinic become more welcoming.

Coupled with inclusive language on clinic forms and visual cues like non-heteronormative posters and brochures, this may result in an MSM patient deciding to stay for his appointment instead of leaving for fear of stigma or judgment.

Once the patient is in the exam room, providers must know what to do. We recommend all primary care providers do continuing education on MSM health issues. This should emphasize the social history – including sexual history and screening for domestic violence, mental illness and substance abuse. Providers should know what risks a particular history implies. They should be ready to discuss STI screening, treatment, transmission and safer sex techniques. To screen correctly, they may need to master new collection methods like the rectal Pap and oropharyngeal swab for gonorrhea and chlamydia. They should also be able to provide information about specialists, domestic violence shelters for men, mental health services and rehabilitation facilities.

We believe these recommendations will best be implemented in larger health care systems first, due to their ability to design, implement, and enforce organization-wide non-discrimination and education policies.

Evaluation

We propose to evaluate our recommendations in three ways – consumer survey to obtain timely consumer feedback on how well needs are met, roundtable discussion to refine continuing education goals, and establishment of a long-term MSM health care task force to monitor progress, evaluate efficacy and look to future developments.

II. Description of the Care Gap

In our work with the Minnesota Department of Health to compile a health needs assessment for men who have sex with men (MSM) we interviewed health care providers from Allina and MSM consumer groups from Pillsbury House, La Clinica, Pride Alive, the Red Door Clinic, and the MN Transgender Health Coalition. The MSM community was a self-identified population of men who included sex with other men in their sexual behavior. There was no formal criterion which the men needed to meet in order to be included in this research.

The MSM community is a large and culturally diverse population of health care consumers. Subgroups within the MSM community include every ethnicity from Latino to Native American to Somali, men who identify as bisexual, and transgendered persons. Many of the unique cultural and socioeconomic determinants of care within each minority milieu fall outside the scope of our more focused needs assessment. We limit our discussion to major causes of health disparities present in all MSM subgroups.

From our meetings with MSM health care consumers and our literature review we identified six major determinants of the health care gap affecting the broader MSM community. These issues are: (1)violence within the community, including both hate crimes and domestic violence, along with their subsequent care, (2)mental health and (3)substance abuse and their treatment, (4)barriers to care related to insurance coverage, (5)appropriate sexual health risk assessment and screening, and (6)appropriate care by the primary care provider to ensure complete care of the patient. Most of the data used to exemplify these issues are from national agencies and were published in nationally renowned academic journals, indicating a high level of data quality.

Violence is a major issue in the MSM community, and one important source of violence is hate crimes against the MSM community committed by outside persons. In a survey of the MSM population in New York City, 20-26% of men indicated that they had experienced anti-gay violence or discrimination on one occasion per year and another 26% experienced this two or more times per year. [1] Hate crimes against the MSM community are very prevalent and are something that most of this community has had to deal with. Furthermore, the incidence of hate crimes against our population of interest is increasing. One study showed an increase of 12% in hate-motivated crimes within the Lesbian, Gay, Bisexual, and Transgender (LGBT) population in 1999.[1] Hate crimes can range in intensity from derogatory comments to death, as was the case with Matthew Shepard, a homosexual University of Wyoming college student who was beaten to death in 1998.[2] It is reported that hate crimes cause more psychological damage than other types of violence because they are not just physical attacks, but also attacks on who the victim is.[1] Studies of the survivors of hate crimes found them to be more anxious, angry, depressed, and more likely to have post-traumatic stress disorder.[1] When violence was discussed with our survey population, they

also reported the occurrence of hate crimes against the MSM community in Minnesota. Incidents discussed included all of the ideas previously discussed plus sexual harassment at work, particularly involving female supervisors. [3, 4] In Minnesota there was a decrease in the number of hate crimes against the LGBT community from 80 to 73 incidents reported between 2005 and 2006. However, those interviewed continued to report on average that they personally experienced 2 to 5 incidents per year, which is consistent with data from 2005.[5] The participants also reported an increase in the amount of public harassment that they experienced.[5]

Hate crimes are a type of violence that is somewhat unique to the MSM community. In 2007, 13 out of 100,000 LGBT individuals were victims of a hate crime.[6] The only other groups which have comparable levels of hate crime victimization are Muslim and Jewish persons; however, these groups are protected by federal law against hate crimes whereas LGBT persons are not.[6]

Violence within the MSM community itself also exists and includes domestic abuse and suicide. A person who identifies with the LGBT community is four times more likely to have attempted suicide than a non-LGBT person.[1] Within the LGBT community nationally, over 25% of people have experienced domestic abuse.[1] This is a higher rate of violence within the LGBT community compared to international domestic violence rates of 1 in 3 women experiencing domestic violence.[7] Domestic violence was discussed with focus groups at Pride Alive and they perceived that the local MSM community also had increased rates of domestic violence relative to the general population, and that there was also a difference in the type of violence. They indicated that there was more violence where both persons involved were violent with each other and somewhat less of the more typical form of domestic violence in which one partner consistently dominated and abused the other.[8] Within the LGBT community in Minnesota as of 2006, the use of weapons in domestic violence increased by 50% and the use of sexual violence in domestic violence increased by 100%. [9] The number of reported domestic violence cases decreased, but it is thought that only 1/3 of cases are actually reported.[9] These statistics demonstrate how great the problem of violence is within the MSM population. Violence within the MSM community is not being adequately addressed by health care providers. and community members experiencing violence do not have adequate resources from which to receive help and support.

Substance abuse is ravaging the MSM community. Men who have sex with men are at heightened risk for substance abuse which has lead to astonishingly high rates of drinking and drug use, especially in the use of “club or party drugs”. [1] A national study of the MSM community stated that within the average individual’s group of friends, 61.6% used “party drugs” like methamphetamine and ecstasy.[1] In 1994, an average of 42.8% of the MSM community had used illicit drugs that year.[10] This statistic can be compared to the national average of 8.3% of adults who used drugs in 2006.[12] Members of the MSM community are three times more likely to experience drug abuse[11] and twice as likely to have issues with alcohol abuse

when compared with heterosexual males.[1] These issues also correlate with lower socioeconomic class.[11] The men and providers we spoke with indicated that they also felt that there was a high incidence of illicit drug use within the MSM community, especially among younger men.[3, 4, 8] In Minnesota, illicit drug use among adults was similar to the national average, but only 0.6% of adults reported using "club drugs" from 2004-2005.[13] This means that the incidence of "club drug" use was 100 times higher in the MSM population than in the state's general adult population.

The problems associated with illicit drug use are much more far-reaching than just addiction, and include increased incidence of HIV infection and increased mental health issues.[1] The use of injectable illicit drugs is related to high risk sexual behaviors and is associated with a high rate of HIV infection. Fifty percent of AIDS infections are related to illicit drug use and the resulting high risk sexual acitivity.[11] Many men in the MSM community have co-addictive disorders along with other mental health disorders.[1]

The MSM community disproportionately uses various mental health services when compared to heterosexual men.[1] When the National Co-Morbidity Survey results are considered for the MSM community, 38.6% of the men who identified as MSM had a mental illness compared to 28.2% of heterosexual men[14], demonstrating a significant difference between the two populations. The particular mental health illnesses which are more prevalent within the MSM community include major depression, panic attacks and bipolar disorder.[1] This issue is particularly important in its relationship to ethnic subsets of the MSM community. The African American MSM community, for example, suffers from more major depressive symptoms than the general population of African American men.[1] The focus groups we interviewed at Pride Alive felt that depression was a major issue in the MSM community and this was a significant concern that they had about their health care.[8]

Another important care gap that we discovered was the lack of primary care STI prevention and screening among MSM. In our consumer focus groups at Pride Alive the majority of participants described a phenomenon of split health care between their normal primary care providers and the providers they see at STI clinics, like the Red Door Clinic. For the most part, sexual health risk assessments and STI screening were not discussed with their primary care providers. While this was only a focus group of approximately thirty MSM, these responses clearly point to a major care gap that warrants further exploration.

The role of the primary care physician as a steward of general health and wellness puts them in a unique position to perform sexual health risk assessment and STI screenings for their MSM patients. The high prevalence rate of drug use, mental illness, and STIs in the MSM population necessitates an ongoing risk reduction dialogue with a physician. It remains a sad fact that MSM within the U.S. face prejudice and injustice in nearly every domain of life. MSM face alienation from family members, co-workers, and peers. To cope with the stress of this alienation many MSM take refuge in drugs and high risk sexual

behaviors. While primary care providers (PCPs) may be ideally suited for the task of screening the risk behaviors of their MSM patients, our findings at Pride Alive and recent research suggest that PCPs, more often than not, leave this task unfulfilled. The high rate of STIs observed in MSM makes this phenomenon particularly alarming. In "Men Who Have Sex With Men: Perceptions About Sexual Risk, HIV and Sexually Transmitted Disease Testing, and Provider Communication" Mimiaga et al. reveal:

> Nearly three fourths (74%) of the overall sample reported telling their current primary healthcare provider (PCP) that they have sex with men. However, only approximately half of the respondents reported having discussions about sexual behaviors with their PCP. Twenty-six percent reported the conversation being prompted by a specific issue—a risk taken, a test needed. Thirty-eight percent reported discussions as a matter of routine care (such as general checkups or yearly physical).[24]

This lack of the discussion surrounding sexual health issues leaves many patients faced with the reality of contracting diseases that are completely preventable. Furthermore, if patients are diagnosed at a free clinic they lack appropriate disease follow up and an ongoing risk reduction dialogue to reduce high risk behaviors.

Research suggests patients engaging in the highest-risk sexual practices are often unaware of the dangers of their behavior. In the same study quoted above, Mimiaga et al. reported that participants at the highest risk stratification for contracting an STI "perceived themselves at low to moderate risk."[24] Most providers would agree that patients rely on PCPs to elicit the proper details in a history to assess risk for disease. For example, PCPs screen patients about diet, smoking, and family history to assess the risk for atheroscelerosis. If this is the case, it begs the question of why PCPs do not assess sexual health risks among their MSM clients.

Primary care physicians are under enormous environmental constrains to limit the amount of time they spend with each patient. Without adequate time, risk assessment falls by the wayside. Furthermore, lack of appropriate training on how to ask sensitive questions further impedes physicians. PCPs may feel unable or unprepared to structure questions in a way that will not offend the patient. Or, they may simply feel nervous about a subject that is still perceived as taboo. This discomfort is often so strong it results in changing the subject or avoiding it altogether. In "Awkward Moments in Patient- Physician Communication about HIV Risk" Epstein et al. quoted one doctor as saying:

> That's just obviously my discomfort because I rushed through: "Yeah, by the way, do you want to talk about that? Okay, great, I'm glad you don't." That issue [is difficult to] deal with not [because] of knowledge, but attitude. And so, is it that I'm dealing with a man that I need to talk about an

> issue of sexuality with? I don't know. Is it that I'm an hour behind in this and I don't want to do it? Or is it a topic that I want to talk about at a different time.[25]

This response underscores the overwhelming discomfort that many PCPs have in confronting issues of MSM health. If PCPs cannot normalize sexual practices that are considered taboo, the patient suffers.

Beyond providing an adequate risk assessment and STI screening, PCPs must be culturally competent. Many of our Latino health care consumers at La Clinica and one of our Indian consumers at Pride Alive reported that PCPs assumed they were heterosexual based on their ethnicity. The Indian consumer stated bluntly that many providers "assume there are no gay Indians." This statement clearly demonstrates that assumptions about different ethnicities must be left at the examining room door.

The logical follow up to most risk assessments is screening for STIs with the appropriate labs and vaccinations. Due to the lack of risk assessment many MSM patients are not receiving these important screening and preventative measures in the primary care context. This represents yet another major care gap for MSM patients. One consumer at Pride Alive described having to request at rectal Pap smear from his primary care doctor. The doctor performed the Pap, but she performed it incorrectly and requested him to come in a second time. He refused because his insurance denied coverage for rectal Paps and the cost was prohibitive. Beyond inexperience with rectal Paps, some of the doctors at the Allina clinic expressed concern that rectal Paps have a decreased sensitivity to detect dysplasia because they are not intended for use in the rectum. The reticence of many PCPs to perform testing is not surprising due to the lack of tools and an established algorithm to screen for STIs among high-risk MSM. Currently, there are no tests specifically geared towards detecting HPV among MSM. In an article on anal intraepithelial neoplasia among HIV+ and HIV- MSM, Palefsky et al. report:

> Identification of women with CSIL through routine cervical cytology screening followed by treatment of the lesion has been an important tool to reduce incidence of invasive cervical cancer. No screening program for ASIL exists that is comparable to that in place for CSIL, but it is possible that an ASIL screening program similar to that for CSIL may be of value to prevent anal cancer in high- risk individuals.[26]

Other measures that are too often left undone include vaccination of MSM patients with Gardasil. While vaccination with the HPV vaccine has not been definitely proven to decrease the risk of rectal cancer in men, it is assumed by many providers that its efficacy spans both genders. None of the men in our focus group at Pride Alive had yet been offered the Gardasil vaccine.

The CDC currently recommends that patients who engage in high risk sexual behaviors receive STI screening every three to six months. Of the men in the Mimiaga study, "100% of the sample had been

tested for HIV at least once and 75% for an STD other than HIV, although only 14% had received their last STD test between 2003 and 2005 and some had not been tested since 1970."[24] Although these men are receiving testing, it is spotty and infrequent. Too often men report waiting to get tested until they are having symptoms of an STI. This "event driven" process, as Mimiaga describes it, could have been prevented with patient education and risk reduction measures. [24]

The frequency of recommended STI testing brings to the surface institutional barriers to care for MSM patients. This represents another major care gap for MSM patients. In our discussion with MSM consumers at Pride Alive many described a general lack of insurance among young MSM who work in the service industry. Although many of these MSM receive care at free clinics, they lack an established primary care physician for follow up and to foster an ongoing discussion about STI prevention. Due to the lack of insurance many MSM wait until they are symptomatic with an STI to seek treatment. If they have a serious condition, such as HIV infection, it may be difficult to procure insurance due to a "pre-existing condition" clause specified by many insurers. The doctors at Allina explained they have seen this happen on a few occasions. Other barriers to continuity of sexual health care included the fear that frequent STI testing would jeopardize insurance coverage. Perhaps the most striking institutional barrier for MSM is the lack of coverage for STI testing. Rectal Pap testing is not routinely covered for most MSM and STI testing is typically not covered if done more frequently than every six months. Additionally, MSM health care consumers with insurance expressed frustration over the lack of resources to help them find gay-friendly doctors. Many had bad experiences with doctors before they stumbled upon a gay-friendly doctor through trial and error or word of mouth. The Gay and Lesbian Medical Association (GLMA) has a referral page for physicians who are either members of the Association or are found to be LGBT-friendly. This is one of the only websites listing physicians who identify as LGBT-friendly. For the state of Minnesota, there are 15 providers[15] listed as options for the Minnesota MSM community. This comprises only 0.08% of the licensed physicians in the state. When the locations of the LGBT-friendly physicians are considered, only two providers are outside of the Metro area with one in Rochester and one in Stillwater. This is a major gap in the care of the MSM community. The lack of providers who identify as LGBT-friendly is a huge barrier to the health care of the MSM community. If these individuals do not feel comfortable with their provider they may not fully disclose important information to the physician or worse, they may not go see a physician with their problems. This issue is only magnified for the MSM communities outside of the Twin Cities area where there are no physicians who identify as LGBT-friendly.

Section III: Causes of the Care Gap

Most of the data used to exemplify these gaps are from well-recognized agencies, both locally and nationally, and much of the data was published in nationally renowned journals, indicating a high level of data quality.

When hate crimes against the MSM community are committed, the offenders are somewhat different from the perpetrators of other types of hate crimes. Only 5% of the people who commit hate crimes against the MSM community are associated with a hate group.[1] The common aspects of the those committing hate crimes targeting MSM are that the offenders have a history of anti-social behaviors and often are thrill seeking teenagers.[1] However, it has been shown that violence is a learned behavior, such that people who have more experience with violence are more accepting of it.[1] However, these are not the only factors contributing to hate crimes. There is a lack of cultural competence in a society which allows this to occur. Hate crimes against the LGBT community and homophobia are more tolerated compared to hate crimes against other groups.[1] This tolerance also includes physicians. This historically has been a problem in the United States. It was not until 1990 that Congress evoked the Hate Crimes Act. But even with this act, there still is no national protection for victims of hate crimes based on sexual identity. In 2007, a bill was brought before Congress to add protection for victims of hate crimes based on their sexual identity, but this was dropped and has not been brought up since.[16] Minnesota is one of few states which have enacted a bill that includes hate crimes based on sexual orientation, but it is not as strong as some would like. If a crime is committed and is found to be motivated based on sexual orientation, the crime severity level is moved up one level which results in a harsher punishment. However, if a crime is already as severe as possible, there is no additional punishment if the crime is hate-motivated. The history of hate crime legislation shows that there has been a gap in the protection of the MSM community for a long time. Most of this comes from a lack of resources for preventative programs and a lack of drive from politicians to cover this gap.[1] Dr. Meininger stated that the cause of the gap in MSM care concerning hate crimes is that there is “no law, no protection, and no research”.[3] This situation results from the tolerance of homophobia, the lack of resources for education and prevention, and the lack of legal protection for the MSM community. There is less of a gap in communities which improve upon these causes. These improvements include sexuality-based hate crime laws with greater legal consequences for sexually motivated hate crimes, a larger presence of the MSM community within the community as a whole, more community resources for victims of hate crimes, and communities that don’t tolerate homophobia of any kind. All of these protective factors would decrease the number of sexually motivated hate crimes within a community. Protective factors at a national level would be less effective since most of the causes of the gap would still be prevalent even with tougher national policies if individual communities tolerate sexuality-based hate crimes.

Patterns of violence are different between men and women in the Unites States. On average from 1993 to 1997, men committed six times more violent crimes than women[17], which shows that men tend to be more violent than women. This is also true in homosexual relationships. Intimate relationships within the MSM community have more domestic violence than intimate lesbian relationships or heterosexual intimate relationships.[1] This data shows that there is a biological factor in the increased incidence of domestic violence within MSM intimate relationships. But the gap in the care of MSM violence is not just due to an increased incidence. There is a lack of training and knowledge on the part of health care providers about how domestic violence in this community should be treated.[1] Part of this lack of training relates to the issue of legal definitions of domestic violence, which are variable from one state to another. In some states, domestic violence is defined as violence between opposite sexed persons.[1] When a member of the MSM community comes to the hospital and wants to report domestic violence in these states, there is nothing that the physician or law enforcement can do for the victim since it is technically not domestic violence. However, in Minnesota, the Domestic Abuse Act of 2007 defines domestic abuse as violence between two family or household members, which includes persons who are residing together or persons with a significant romantic or sexual relationship.[18] This act would include members of the MSM community who experience domestic violence. The gap in care for MSM domestic violence in Minnesota is due more to the lack of economic resources for the support of the victims. Many physicians have trouble treating MSM victims due to the idea that the domestic violence resources are set up for female victims.[4] This is because historically, women have been viewed as the only victims of domestic abuse. Men are not seen as victims of domestic violence because they are supposed to be tough and "take it like a man".[1] There are very few, if any, safe housing programs for men who have experienced domestic violence and usually the men are not welcome at the safe houses for female victims.[19] The gap in the care of domestic violence is caused by a lack of policies, procedures, and programs.[1] There is also the influence of homophobia and gender bias on the part of the provider; if the provider does acknowledge that men can be battered, they can help the men find resources.[20] However, some battered men do better than others. It has been found that one of the major protective factors is the men having a support system outside of the person who abused them.[5] This provides them with the resource of a safe place to go, something that many providers can not give to them. Men who have this support outside of the abuser will feel less isolated, which will help to keep the victim from returning to his abuser.[5] Another protective factor is a physician who is educated about domestic violence within MSM relationships. An open physician will be better able to treat abused men since the men will feel comfortable telling the physician about the abuse and the physician will able to assist the men in finding local resources that are available for them. Someone needs to step in to end the cycle of violence within the MSM community, and this must be the providers whom the men seek out for help.

The issues of drug abuse and mental health problems are intertwined with each other. Many of the MSM community members are using drugs to self-medicate mental health problems including depression and anxiety, as well as to increase their self-confidence and improve how they feel about their sexuality.[1, 3] The MSM community is at a higher risk for addiction and drug abuse due to an increased amount of problems with control.[1] This leads to the MSM community having an increased need for substance abuse treatment.[1] Historically, the MSM community relied on heavy partying as a means for socialization.[8] This is still somewhat true in the current MSM community but is felt to be more common among the younger men.[8] With the reliance upon clubs and bars, which frequently involve substance use, for socialization, it is easy to understand how substance abuse is a major issue for the MSM community.[1] The men in our focus groups at Pride Alive discussed some of the social reasons for using various substances, which included: "because sex is better fucked up," "because minorities need crutches," "because of how society views gay people," that they "already feel like deviants, so go big or go home," and "peer pressure."[8] All of these reasons show how intermixed substance use is with socialization in the MSM community and the health of the men. There are very few options outside of the club scene for the MSM community to socialize.[1] The abuse of drugs within this community is also influenced by economic reasons. The rate of substance abuse is much higher in the lower socioeconomic classes within the MSM community.[1] The gap in care for substance abuse and treatment is due to financial barriers to appropriate treatment, a lack of culturally appropriate treatment, a lack of personnel trained in the needs of the MSM community, and a lack of knowledge within the MSM community about treatment options.[1] In a study on how knowledgeable providers felt they were on LGBT needs concerning substance abuse treatment, they stated that they received little training or education on the needs of LGBT clients.[21] They felt particularly unknowledgeable in the areas of legal issues, the dynamics of domestic partnerships, and the idea of internalized homophobia.[21] Though there has been little research on effective treatment of substance abuse due to economic constraints, there have emerged some protective factors for the MSM community. The MSM community itself can be protective when there is a movement away from the party scene and an inclusion of more drug-free events.[1] The use of individually oriented treatment has been shown to be effective for the MSM community along with education within the community about treatment options.[1] When men of the MSM community have high self-esteem and confidence, they are less likely to turn to drugs.[1]

Mental health issues are a problem that affects many people, but they are even more prevalent in the MSM community. There are many reasons that the MSM community would experience more mental health problems than others, including having to "come out" to friends and family and dealing with lifelong infectious diseases which disproportionately affect this community. Many of the MSM community members feel that they are different when they are growing up, which is especially difficult to

deal with as they experience puberty.[1] When the men consider the process of coming out, there is much anxiety associated with being known as a gay man.[3] There is a continuation of different challenges the community members must face during their lives which increase the chance of mental illness if they do not posses appropriate protective factors. HIV-positive members of our focus groups at Pride Alive indicated that they have struggled with mental health ever since they were diagnosed with HIV.[8] They stated that there is depression associated with the diagnosis of a lifelong illness like HIV and with treatment failures that require medications to be switched.[8] There is also the anxiety of dating within the MSM community knowing their HIV status.[8]

Men who have sex with men are unlikely to seek out mental health care for many reasons. Due to the history of homosexuality being considered a mental illness, many men are hesitant to approach a provider who may still believe that their sexuality is an illness.[1] Until the 1950's, the DSM classified homosexuality as a diagnosis of mental illness. [1] There is still a diagnosis for children which classifies homosexual boys as having a mental illness, and some providers still treat the MSM community with reparative or conversion therapy to try to correct and reverse their sexuality.[1] There is also an issue with homophobia on the part of health care providers. In one study, up to 25% of psychiatric faculty polled admitted that they were homophobic.[1] This is a major problem when members of the MSM community try to find a provider for their mental health needs. The men have very few resources which list mental health providers who identify as LGBT-friendly, and then they must try to pay for the treatment which may or may not be covered by insurance. Without insurance, many men can't afford treatment which can cost up to $100 an hour and may last for significant periods of time.[19] All of these factors, including a lack of trained and qualified providers, increased incidence of hardship throughout their lives, financial barriers to care, and the stigmatization of receiving care for a mental health problem, contribute to a significant gap in the health care of MSM. The gap is further magnified in more rural areas where providers have less exposure to the LGBT community and are not as educated on issues which need to be addressed in LGBT patients.[22]

Certain protective qualities exist which decrease the degree to which some men must struggle with the mental health care gap. Individuals are more likely to receive care for their mental health if they are screened more often for mental health problems by their primary provider.[1]There is a decrease in the number of suicide attempts after a person has come out and addressed their sexuality[1] publicly, rather than internalizing their feelings. The men who struggle less with mental health are found to have better coping and adaptive skills, including accepting communities and support groups. Finally, isolation is known to lead to more mental health problems.[1]

Trying to assign a cause for the gap in appropriate care by a primary provider for the MSM community is difficult because it is very specific to the particular community in which an individual lives,

and depends on the resources and attitudes of that community. The population of Minnesota can be grouped into two large areas, the Metro area and outside of the Metro area. When a member of the MSM community is living in the Metro area, it is much easier to find a LGBT-friendly provider.[3, 8] This is because there are a larger number of identified LGBT-friendly physicians in the area and the MSM community has a greater presence within the Metro area and has access to more resources to find a physician. This allows the men in the Metro area a greater selection of physicians so they can find one that works well for the individual. Dr. Meininger indicated that he will initially see an individual who is looking for a physician for a minor problem and then the patient will come back for more serious and personal issues if they felt that the physician treated them appropriately.[3] This process generally cannot take place outside of the Metro area. There are only two LGBT-friendly providers identified by GLMA outside of the Metro area, and there are none in the northern part of the state.[15] Outside of the Metro area, the care gap is magnified due to the lack of identified LGBT-friendly providers and lack of resources in these areas to help find a LGBT-friendly provider.

Throughout Minnesota, much of the care gap can be attributed to provider and clinic ignorance and lack of education[3]. The rate of homophobia among physicians has greatly decreased since it was first analyzed in 1982, but it is still present, especially when the physician is treating members of the LGBT community who are HIV-positive.[23] But providers can help to close this gap regardless of whether it is caused by a lack of friendly providers or by homophobic attitudes. There needs to be an increase in the training of physicians on the needs of the MSM community so that when a community member comes in to be seen, the providers know how to appropriately treat the patient both medically and culturally.

IV. Previous Attempts at Reducing the Care Gap

The healthcare gap that exists for the MSM community has been recognized for a number of years, and there have been many attempts to reduce that gap. Many of these attempts coincide with the recommendations presented in this paper. It is very important to critically evaluate the effectiveness of other programs to plan the best possible intervention. To give a glimpse as to what has been tried to reduce the gap we will review a number of articles describing health-promoting programs aimed at the MSM community.

It is to be noted that many programs do not publish scientific articles documenting their effectiveness. When reviewing the literature focused on improving MSM health, the overwhelming majority of academic literature published on this topic was addressing programs combating various STDs in the MSM population and fewer articles addressed other aspects of MSM health and barriers to care.

In order to address the increase in the number of cases of syphilis, especially among men who have sex with men, the New York City Department of Health and Mental Hygiene (DOHMH) established

a wellness-focused program called “Hot Shot!”[27] Previous anti-syphilis efforts focused on screening for syphilis alone have not been highly effective, and DOHMH attempted to make the screening program reach more MSM, especially those with higher risk. DOHMH did this by offering other health screening and services along with the syphilis screening. Based on information gathered from several community health surveys and profiles and the help of community partners, DOHMH designed a package of “transportable” interventions that specifically addressed documented health concerns of the neighborhoods most affected by syphilis. This package of services included screening tests (hypertension, diabetes, hypercholesterolemia, depression, drug abuse), STD testing (HIV, syphilis, gonorrhea, chlamydia), vaccinations and referral services (GLBT-healthcare providers, tobacco cessation, crystal methamphetamine counseling). DOHMH then hired a party promoter to organize and advertise Hot Shot! events at non-medical entertainment settings, such as bars and clubs, with the goal of reaching people that would not normally access healthcare. The events would offer the package of wellness-promoting services, and follow-up on any testing would be done by local STD clinics or by phone/mail.

The outcomes from this intervention were measured in number of people accessing the services and the number of positive testing results and referrals. From November 2003 to June 2004 there were 9 Hot Shot! events, 6 of them at commercial clubs and 3 at a GLBT community center. Over the course of the 9 events, 1,634 people attended the events, and of those, 445 utilized at least one of the services. 691 vaccinations were administered (226 Hepatitis A; 239 Hepatitis B; 214 Influenza; 12 Pneumococcal). There were 329 health screenings conducted and 8 referrals were made for depression/mental health, 1 referral for diabetes, no referrals for hypercholesterolemia, 2 referrals for hypertension, and 13 referrals for substance abuse, of which 4 were for crystal methamphetamine use. 692 STI tests were done, and 7 new cases of HIV, 4 new cases of syphilis, 1 case of gonorrhea and 2 cases of chlamydia were identified. 64 participants received tobacco cessation counseling, and 50 received nicotine patches.

The Hot Shot! program, along with programs in other areas, was able to integrate sexual transmitted disease screening programs with other health-promoting services targeting the MSM community. By having a holistic approach to STD-screening efforts, DOHMH was able to increase syphilis screening in the relevant populations, and offer many other services that address non-sexual health concerns. One limitation of this study is that it only recorded how many tests they did and how many referrals they provided, but did not collect data on the rate of follow-up from these referrals. Measuring how many presented at the referral sites would be a good measure of the real effectiveness of such screening events. Nevertheless, this study showed that by screening for a number of health issues and providing referrals to appropriate GLBT-sensitive healthcare providers and other programs, there is potential to improve not only STD screening, but also overall MSM health.

Other efforts to bring STD screening services to the MSM most at risk extend beyond clinics, and even clubs, to the internet. The H.I.M. project at the Red Door Clinic in Minneapolis will chat with people online, encouraging people to receive STD testing, and provide information regarding safe sexual behaviors.[28] They are able to find chat rooms used to find sexual partners, and use that space to provide sexual health information. Another use for the internet to fight the spread of some STDs is pseudonymous notification emails. Sites such as www.inspot.org offer a way for someone recently diagnosed with an STD to notify their recent sexual partners anonymously, and recommend that the person get tested.[29,30]

In addition to screening for STD's and referring, efforts have been made to limit transmission of STD's by adding counseling on risky sexual behaviors prior to STD tests. The CDC currently recommends a 30-minute counseling session with the HIV antibody test, which includes assessment of HIV knowledge and risk behavior, and negotiation of a realistic plan for reducing risk. Efforts have also been made to improve upon these interventions and make them more effective. Dilley et al. (2007)[31] developed a 50 minute intervention that focused on self-evaluating the justifications one uses for engaging in risky sexual behaviors. The efficacy of this intervention was evaluated using a randomized controlled trial and evaluated on rates of unprotected anal intercourse (UAI) prior to and after the intervention.

Participants were MSM who had received at least one HIV-negative test prior to enrollment, and at least one episode of UAI with a nonconcordant HIV serostatus (unknown or HIV+) individual in the last year. The participants were randomly assigned to have a single-session personalized cognitive counseling (PCC) intervention or the usual counseling (UC) recommended by CDC guidelines. The 30 minute UC intervention includes assessment of HIV knowledge and risk behavior, and negotiation of a realistic plan for reducing risk. In addition to this standard counseling, the PCC intervention included having the participant complete a "self-justifications" questionnaire that asked about the thoughts preceding a recent episode of UAI the participant had with a nonconcordant HIV serostatus individual. After the questionnaire, the participant narrates to the paraprofessional counselor the events that led up to the episode of UAI, and the two discuss any identified self-justifications and how they can be addressed in the future.

The effectiveness of the counseling interventions was assessed by comparing the frequency of episodes of UAI during the 90 days prior to the study, and 6 and 12 months after the intervention. These rates were obtained by interviews with the participants.

For the PCC participants, the average number of high-risk sex episodes was 4.2 in the 90 days prior to the intervention, 1.9 episodes after 6 months, and 1.9 episodes after 12 months. The UC participants averaged a similar level of 4.8 episodes prior to the intervention, 4.3 episodes after 6 months, and 2.2 episodes after 12 months.

This study demonstrated that counseling repeat HIV testers regarding high-risk sexual behavior combined with HIV screening can be effective to decrease the frequency of repeated risky behaviors, and that adding counseling regarding self-justifications increases the effect. Counseling everyone may be ideal, but the large time commitment may be discouraging to MSM and would increase costs. More studies need to be conducted to determine the intervention's cost-effectiveness.

There are other medical conditions that disproportionately affect the MSM community, and among them is an increasing prevalence of anal cancer, especially with HIV-positive MSM. Anal cancer has been associated with HIV infection along with HPV. Anal cytology has been shown to detect precancerous anal lesions (anal intraepithelial neoplasia) and to be cost effective in both HIV positive and negative MSM.[32,33] Translating anal cytology screening into clinics as part of routine care is the next step in increasing screening for and decreasing mortality from anal cancer.

Scott et al. (2008)[34] studied the integration of routine anal cytology into an urban HIV clinic. Starting in 2002, 6 providers received training on the anal cytology procedure, and all patients were offered the screening as part of routine care. The samples were all read by one pathologist trained in reading anal cytology, and classified based on degree of neoplasia. Atypical cells of undetermined significance (ASCUS), anal intraepithelial neoplasia (AIN)I, AIN II, and AIN III were referred for anoscopy and surgical evaluation. Chart reviews were conducted on those receiving anal cytology for other clinical factors.

Over the course of 2 years, 49% of patients seen in the clinic received at least one screening anal cytology. Of the included anal cytologies 191 were normal and 74 were abnormal. Of the 74 patients with abnormal cytology, only 50 (66%) were referred for surgical evaluation, of which 27 patients received anoscopy, 14 received an anal exam or repeat anal cytology, and 2 were unable to tolerate anoscopy. Of the 27 anoscopies, only 9 received biopsies of lesions.

This study demonstrated that anal cytology can be used as part of routine care. However, it also demonstrated many of the challenges posed by integrating such a screening protocol into the clinic. Anal cytology was generally well tolerated by patients, but fears of the procedure and the cancer diagnosis prevented some patients with abnormal cytology from pursuing anoscopy. In addition, physician training was also a problem, with several patients referred for surgical consult receiving anal exams or repeat cytology, even though they should have been receiving anoscopy. The study showed that limiting follow-up visits to only a few providers and adding additional training helped with protocol adherence.

When a clinic is planning on incorporating anal cytology into routine care, the difficulty with ensuring that providers are adequately trained must be addressed. Despite these organizational difficulties, implementation is important, as 2 patients in this study were identified with SCCIS and successfully treated.

Although most published projects addressing MSM health are focused on STD public health, there are many other initiatives tackling other dimensions of MSM health. Projects like the GLBT Health Access Project have addressed improving provider training to increase GLBT-sensitivity and increase knowledge of GLBT-specific issues.[35]

The GLBT Health Access Project is a collaboration of the Massachusetts Department of Public Health, community-based health and human services agencies, and GLBT individuals and allies. The goal of the project is "to raise awareness of health issues; reduce barriers to health care and prevention services and improve health norms for GLBT persons across Massachusetts." The first step in the project was to develop community standards of practice generated by a group of healthcare providers, community-based agency representatives, and consumers. The project then created a training curriculum and technical assistance component to implement the community standards. Finally the GLBT Health Access Project worked to collect and publish GLBT-specific health-related data.

The effectiveness of the GLBT Health Access Project's efforts was measured by the satisfaction providers and consumers had with the community standards, the participation in and effectiveness of the training, and the quality, quantity and utility of the GLBT-specific health-related data. After a large initial interest in the training, 10 training sessions were completed, with 324 individuals from 89 agencies within Massachusetts participating. The participants were uniformly satisfied with the training, and showed a positive, but not statistically significant, attitude change.

This project yielded a community standards document that has withstood a reasonable amount of scrutiny, and would make a very good starting point for healthcare institutions drafting their policies. The training component of the project did positively affect attitudes, but did not do so significantly. The evaluation of the training measured attitude change, which would likely be hard to affect in a single 3 to 4 hour training session, and did not measure behavior change. A change in attitude and knowledge is necessary for many primary care providers to better serve the MSM community, and this will need to happen in efficient and effective trainings.

The selection of projects improving the health of MSM that were reviewed here only represents a small subset of many efforts nationwide. There are many areas that must be addressed to reduce the healthcare gap between MSM and the general population. Going forward it is important that programs review the literature while designing their interventions. It is equally important that these programs evaluate their interventions effectiveness, to help improve the methods by which MSM healthcare is addressed. Building public health efforts with a strong literature-supported foundation will ensure they are effective in improving MSM health.

V. Recommendations

The following recommendations for best practices in improving the delivery of quality health care to the Minnesota GLBT community, and more specifically the MSM community, are based on a review of the current literature and interviews with MSM healthcare consumers and their health care providers. Recommendations are made for each of the following levels of health care delivery: public policy, the healthcare system, the clinic, community-based programs, health care providers, and healthcare consumers. The six major determinants of the health care gap: violence within the MSM community, mental health, substance abuse, health insurance coverage, sexual health risk assessment and screening, and appropriate care by the PCP, are addressed with specific recommendations or suggestions for broader cultural and societal transformation.

GLBT patients live and seek healthcare and prevention services in all communities, therefore a national health care standard should be developed for the equal treatment of GLBT patients and their family members.[36,37] As stated in a document by the GLBT Health Access Project, "Eliminating barriers to care requires both an educated and empowered consumer base and a skilled, culturally competent, sensitive and welcoming provider community that is openly supportive of gay, lesbian, bisexual and transgendered people and their families."[36]

MSM and their PCP:

Public policy:

- Include GLBT health care questions on all Medical Board exams and national and local health care personnel licensing exams.[37]
- Require training, internships or rotations in health centers or community centers that serve GLBT patients for all persons preparing for careers in healthcare.[37]
- Maintain and widely advertise a national database of GLBT-friendly providers and health care programs.[37]
- Research on all health-related issues, both privately and publicly funded, should include identification of GLBT individuals when appropriate.[37]

Health care system:

- Establish and implement system-wide comprehensive non-discrimination policies regarding sexual orientation or gender identity.[36,37]
- Establish a clear protocol for filing discrimination complaints and actively investigate any complaints.[36,37]

Clinic:

- Train all staff, from front-line staff to laboratory personnel, in sensitivity, empathy, the appropriate use of language and important GLBT health issues.[36,37,38,39]
- Train all staff on local, national and online resources available for GLBT individuals.[39]
- Actively recruit and employ GLBT employees and encourage their visibility within the clinic. [36]
- Create inclusive forms for use in the clinic. For example, use terms such as "spouse or partner" in place of just "spouse" and "relationship status" instead of "marital status." It is also important to include accurate family relationships and gender identities on clinic forms. [36,37,38,39]
- Provide visual clues, such as posters, brochures and patient information, to indicate an environment welcoming to the GLBT patient. [36,37,38,39]

Community-based programs:

- PCPs and community-based programs should work in conjunction to ensure widespread knowledge of existing programs to service the GLBT community. [36,37]
- PCPs and community-based programs should work in conjunction to develop additional programs to fill in gaps in coverage and care for GLBT patients and their families. [36,37]
- PCPs and community-based programs should work in conjunction to secure funding to increase the quantity and quality of community-based health-related programs serving the GLBT community. [36,37]

Health care providers:

- Maintain strict confidentiality in discussions and disclosures of sexual and gender identity. [36,37,38,39]
- GLBT-friendly providers should list themselves on online provider directories to facilitate GLBT access.[39]
- Participate in continuing education programs related to GLBT health issues.
- Become more involved and visible in the MSM community.[36]

Health care consumers:

- Encourage GLBT-friendly providers to list themselves on online provider directories to facilitate GLBT access.
- Complete evaluations and surveys of PCPs, clinics and health care systems to help improve quality of service to the GLBT community.
- Become involved in governing boards of health care systems, clinics or community programs to help institute improvements in care for the GLBT community.[37]
- Be willing to discuss and educate PCPs and other clinic personnel on health, language and cultural issues related to the GLBT community.

MSM Community Violence:

Public policy:

- Amend the Federal Hate Crimes Act to include protection for victims of hate crimes based on sexual orientation or gender identity.
- Amend domestic violence legislation to include same sex and domestic partners in prevention and intervention services. [37]

Health care system:

- Establish and enforce system-wide policy to prevent violence against GLBT individuals in the workplace. [36]

Clinic:

- Ensure that all staff members are knowledgeable about local, national and online resources available to GLBT victims of violence. [37,38]
- Provide staff with training regarding the laws related to violence in the GLBT community. [36,37]

Community-based programs:

- Provide shelters or safe-havens for male victims of domestic violence.
- Create services to address domestic violence within the GLBT community. [37]
- Develop programs to educate the general population that violent acts against GLBT people are illegal and will not be tolerated.[37]

Health care providers:

- Screen GLBT patients for mental and physical violence when suspected, as they would for heterosexual individuals.[37]
- Be aware of the potential for abuse and violence within and against the GLBT population.
- Be knowledgeable about and provide referrals to local, national and online resources available to GLBT victims of violence.[37,38]

Health care consumers:

- Become involved both locally and nationally in the discussion about violence within and against the GLBT community.[37]
- Become involved or initiate awareness campaigns locally about the issue of violence within and against the GLBT community.

MSM Mental Health:

Public policy:

- ❖ Federal programs such as Medicaid, Medicare and Children's Health Insurance Program should require culturally competent services for GLBT people.[37]

Health care system:

- ❖ Should include culturally competent and consumer-driven mental health care programs for GLBT people. [37]

Clinic:

- ❖ Educate all clinic staff about the issues specific to the GLBT community that can add stress and increase risk of depression and other mental health problems.[36,38]
- ❖ Ensure that all staff members are knowledgeable about local mental health resources available to GLBT people. [37,38]

Community-based programs:

- ❖ Increase knowledge and visibility of established mental health resources for the GLBT community.
- ❖ Develop additional programs for the care of GLBT people with mental health needs.

Health care providers:

- ❖ Understand that stigma associated with sexual orientation, homophobia, discrimination and other issues can increase the risk of stress, anxiety, and depression in GLBT people.[37,38]
- ❖ Conduct mental health and depression screening when appropriate.[38]

Health care consumers:

- ❖ Educate themselves and other GLBT community members on the resources available for mental health care.
- ❖ Support and encourage treatment for GLBT community members that may be suffering mental health issues.

MSM Substance Abuse:

Public policy:

- ❖ National substance abuse surveys should include sexual orientation and gender identity as demographic variables for study.[37]

Health care system:

- ❖ Substance abuse screening, prevention and treatment programs should include GLBT culturally competent language and address culturally competent issues. [37]

Clinic:

- Train staff to understand that GLBT people can be more vulnerable to social and personal stresses that can result in increased substance and tobacco use.[38]

Community-based programs:

- GLBT people should be included in substance abuse program planning in a culturally competent manner.[37,38]
- Develop outreach programs to educate GLBT youth about substance abuse prevention and treatment options.[37,38]

Health care providers:

- Understand that GLBT individuals can be at increased risk for substance abuse and tobacco use.[37,38]
- Screen GLBT patients in a culturally competent manner for substance and tobacco use.[37,38]
- Present prevention and treatment options along with referrals for GLBT-friendly treatment programs.[38]

Health care consumers:

- Become involved both locally and nationally in the discussion about substance abuse and tobacco use within the GLBT community.
- Educate themselves and other GLBT community members on the resources available for substance abuse and tobacco use treatment.
- Support and encourage treatment for GLBT community members that may be suffering substance abuse and tobacco use issues.

MSM Health Insurance:

Public policy:

- Pass legislation at the Federal level that establishes legal mechanisms for the recognition of same-sex couples.[37,39]

Health care system:

- Provide health insurance for employees' domestic partners and nonbiological children.[39]
- Offer and provide coverage for rectal Pap smears to detect early rectal cancers.[38]
- Offer and provide coverage for Hepatitis A, Hepatitis B and Human Papilloma Virus vaccinations for at-risk GLBT people.[37,38]

Clinic:

- Offer STI screening and HepA, HepB and HPV vaccines at a reduced fee for uninsured at-risk patients.

- Train staff on the appropriate technique for performing a rectal Pap smear.
- If unable to provide services at a reduced rate or for free, be able to appropriately refer uninsured patients to GLBT-friendly or GLBT-specific clinics for STI testing, vaccines and other healthcare services. [37,38]

Community-based programs:

- Secure funding to increase programs offering health care and prevention services for underinsured and uninsured GLBT people.

Health care providers:

- Offer health care and prevention services for underinsured and uninsured GLBT people.
- Volunteer in the community for programs that offer services for underinsured and uninsured GLBT people.
- Work with groups locally and nationally to ensure fair health coverage for all GLBT people. [36]

Health care consumers:

- Demand research on the effectiveness of the HPV vaccine in the male population.
- Demand research on the effectiveness of rectal Pap smears on the early detection of rectal cancers.

MSM Sexual Health Risk Assessment, Screening and Prevention:

Public policy:

- Implement a national STI prevention program for GLBT people that specifically address the racial, ethnic, geographic, cultural and age differences of individuals in this population.[37]
- Increase research to examine and reduce barriers to appropriate sexual health risk assessment, screening and prevention.[37]

Health care system:

- STI media campaigns should include the GLBT population. [37]

Clinic:

- Provide GLBT-appropriate literature about sexual health risk assessment, screening and prevention.[38]

Community-based programs:

- Secure funding to increase programs for STI testing and vaccination for at-risk GLBT people.
- Provide culturally appropriate STI prevention outreach programs for GLBT youth.[38]

Health care providers:

- Regularly incorporate sexual health risk assessment, screening and prevention discussions in routine health maintenance visits with GBLT people. [37,38]

- Be prepared to discuss safer sex techniques and answer questions related to the transmission of HIV and other STIs.[38]

Health care consumers:

- Become educated on sexual health risks and request screening tests from health care providers.

VI. Evaluation

For far too long, reports on MSM health care have been tucked away in file cabinets while efforts to make changes in the healthcare system have been stunted by more mainstream problems. The reason that the issue of MSM health disparity falls on deaf ears is because many of these reports failed to follow up on their recommendations with hard evidence on outcomes of the proposed resource use and policy changes. To fix this problem, we are now proposing tangible ways to evaluate the efficacy of our recommendations given adequate funding and resources. Our three evaluation methods include a consumer survey, clinician training evaluation through roundtable discussions, and a task force to monitor progress and evaluate efficacy.

Our first proposal is a consumer survey in order to assess how patients perceive their care, if there was improvement with better clinician training, and most importantly, what should be improved in MSM healthcare. We propose that this survey be modeled after the Vancouver Trans Survey,[40] wherein the authors suggested a variety of methods to make the survey more accessible, confidential, and convenient for consumers. This includes uploading the survey onto websites associated with MSM healthcare, making the forms available at MSM community organizations, and mailing the surveys out to MSM patients. In addition, a team of volunteers would be given the task of conducting face-to-face interviews with patients at various community clinic sites that provide services to MSM. Finally, surveys like these should be advertised through announcements, posters, and brochures in order to reassure MSM patients that their thoughts are valuable and that they can help improve or tailor the way healthcare is being provided.

Our second proposal deals with clinician training and evaluation of efficacy through roundtable discussions. Our goal is similar to the goals of the LA Gay & Lesbian Health Roundtable in 2002[41], which are to open up the discussion of MSM health, to generate further recommendations, and to develop ideas for building a capable healthcare system to serve MSM patients. Through the format of discussing problems rather than lecture-based or online training courses, we hope that clinicians would be more interested in participating and that the education process would be more interactive. In addition, through open discussions, we can better educate healthcare allies, bring up new ideas, and organize group efforts at implementing changes in the provision of health care to men who have sex with men.

Our last proposal is formation of an MSM health care Task Force in order to monitor progress as well as to evaluate the efficacy of programs. This Task Force should be modeled after the National Gay and Lesbian Task Force Policy Institute, which oversees a host of political activist programs, advocates for research, and publishes newspaper articles and annual reports on GLBT healthcare needs.[42] Similarly, the function of our MSM Task Force is to follow up with patients through the different survey means listed above, to arrange for clinician training and roundtable discussions, and to publish annual reports on the progress and efficacy of new changes in MSM health care provision and recommendations for future improvements. If given adequate funding, the MSM Task Force can expand to include the additional responsibility of familiarizing the general population with MSM issues through press coverage such as newspaper articles, radio talks, etc.

With these new ways to evaluate efficacy, we hope that issues surrounding MSM health care needs will finally be recognized and addressed in the clinical setting. Furthermore, if we can show good efficacy for our recommendations to improve MSM health, we would be able to obtain future funding for other improvement projects.

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APPENDIX A

Questionnaire for Health Care Providers and Experts

We are interested in learning about
I) health issues facing MSM (men who have sex with men)
II) barriers that prevent or hinder access to/utilization of necessary health care services

I. Health issues

1. When a male patient discloses that he has sex with men, what major health concerns should the provider know about/be ready to address?
    a. infectious disease – STIs, Hepatitis B, HIV/AIDS, opportunistic infections
    b. cancer
    c. chronic conditions
    d. mental health (e.g. depression, eating disorders)
    e. substance abuse – nicotine, ethanol, prescription drugs, illicit drugs
    f. safety in the home or in the community
    g. sexual health screening, treatment, and prevention
    h. patient education

2. How do health concerns change depending on specific community subsets of MSM (monogamous, non-monogamous, race, ethnicity, immigrant, bisexual, transgender, age, institutional, married, other)?

3. How is the management of chronic conditions complicated in MSM patients?

4. How is the continuity of care different for MSM patients?

5. What sort of fears and institutional distrust do MSM have concerning health care providers or institutions?

6. How frequently are rectal Pap smears done for MSM patients?

7. What concerns do providers have about offering rectal Pap smears to their patients?

8. What problems do you foresee with administering the HPV vaccine to men?

9. Are rectal Pap smears of the HPV vaccine in men reimbursed by insurance?

II. Barriers to care

Insurance

1. What percentage of (your) MSM patients have health insurance (private or government subsidy)? If they do not have health insurance, how do they pay for their care?

2. Do you have difficulty getting reimbursed (private or government subsidy) for the care (screening, treatment, management, prevention, patient education) you provide MSM patients?

3. Are there reimbursement issues for any of the following:
   a. rectal Pap smears
   b. oropharyngeal, genital, or rectal swabs for STI assessment
   c. the HPV vaccine
   d. other

4. Do you offer/provide these services anyway? How are the services paid for?

Medical knowledge/research

5. Are there nationally approved guidelines in place for health assessment of MSM patients?

6. If yes, what are the guidelines? How were they chosen (research, consensus of providers)?

7. If no, does your organization or clinic have its own guidelines in place for health assessment of MSM patients? How were they chosen?

8. What research has been done/is being done on MSM-specific health problems (epidemiology, screening, treatment and prevention)?

9. How are research projects, outreach programs, and prevention campaigns that target MSM health funded?

Point of care

10. We are very interested in how the clinical environment affects the comfort level of MSM patients who access care.

11. How does your organization or clinic try to make the environment welcoming to all types of people? (i.e. forms, brochures, posters). Where do you get these materials?

12. What sort of diversity training does your staff receive? Who designs the training protocol?

13. How were you trained to take a thorough but respectful sexual history?

14. What are the integral components of taking a history from an MSM patient?

15. How were you trained to assess and respond to sexual health risks for the many communities that fall under the broader category of MSM (monogamous, non-monogamous, race, ethnicity, immigrant, bisexual, transgender, age, institutional, married, other)?

16. What assumptions should a provider try to avoid when seeing an MSM patient?

17. What literature do you think is useful for developing "cultural competency" for the variety of MSM groups?

18. How is knowledge of MSM-friendly organizations, clinics, and providers distributed to consumers (word of mouth, publications, advertising, internet)?

19. What thoughts do you have about how to best generalize the things your organization or clinic does to those that a setting that does not deal with a large MSM patient population?

APPENDIX B

Questionnaire for Patients/Consumers

We are interested in learning about
I) health concerns you have
II) any barriers that keep you from accessing or utilizing necessary health care services

I. Health issues

1. Do you think there is a higher rate of nicotine, alcohol or drug use among MSM? If so, why do you think this?
2. Do you feel that MSM deal with a higher rate of violence, either in the community or in relationships?
3. Has your health care provider ever addressed the issue of nicotine, alcohol or drug use with you?
4. Has your health care provider ever addressed the issue of mental health with you?
5. Has your health care provider ever addressed the issue of violence and safety with you?

Screening and Prevention

6. Do you regularly get checked for STIs? Which ones? How often?
7. For STI evaluation do you see your regular provider or use a free clinic?
8. Have you ever experienced any difficulties getting tested? In what ways?
9. Have you heard of the HPV vaccine? If so, has any health care provider offered you the vaccine?
10. Have you heard of rectal Pap smears? If so, has any health care provider offered this exam to you?
11. What health concerns do you wish a provider would address?

II. Barriers to Care

General

1. Do you think that MSM have a more difficult time accessing health care than the general population? If so, can you give any examples that make you think this?
2. Do you think that the quality of care a MSM patient receives (when he does access the health care system) is inadequate? Why?
3. What do you think are the major causes of these disparities?

Insurance

4. Do you have health insurance? If you are partnered, do your partner have health insurance?
5. Are you both able to access coverage through one of your plans?
6. If neither has insurance, how do you pay for healthcare?
7. Has your insurance ever denied coverage for a procedure or lab test that relates to your sexual health or gender identity?

Point of Care

8. Do you see a health care provider on a regular basis?
9. How do issues related to your sexuality or gender identity affect how, when and where you seek care?
10. Are the clinics where you get care welcoming of MSM patients?
    a. If yes, how does the clinic environment make you feel welcome?
    b. If no, what could be changed to make the environment better?
11. If you want to find an MSM-friendly provider, how do you go about it? Word of mouth, community organizations, newspaper/magazine ratings, internet, other?

12. Does your provider ask you about sexual behaviors? How/when do they ask?
13. Has your provider ever addressed the topic of sexual health risks with you?
14. What do you think is the best way to ask a patient about sexuality?
15. If they don't ask, do you do disclose your sexuality to your provider? How comfortable are you doing this? Do you pick and choose what to reveal?
16. Do you think a provider needs to know about your sexuality?
17. Do you feel comfortable talking to a provider about MSM health issues?
18. Have health care providers ever made assumptions about you, based on disclosure of sexual activities?

Community Diversity

19. What additional issues are important within your racial, ethnic or cultural community?
20. Do health care providers make assumptions about your sexuality based on your appearance or cultural identity?
21. Are there any cultural or language barriers that prevent or hinder you from accessing healthcare?