Improving Sexual Healthcare among Men who have Sex with Men (MSM): The Power of Performance Indicators

Jessica Klajman[1], Nana P. Mensah[1], Angela Merges[1], Zoe Edelstein[1], Demetre Daskalakis[1], Julie Myers[1,2]

[1]New York City Department of Health and Mental Hygiene, Queens, NY; [2]Division of Infectious Diseases, Department of Medicine, Columbia University Medical Center, New York, NY

ISSUE

- Chlamydia and gonorrhea are two commonly diagnosed sexually transmitted infections (STIs) among men who have sex with men (MSM), and are considered co-factors for HIV transmission and acquisition.
- For MSM at highest risk of HIV, the CDC recommends 3-site (urethral, rectal, and pharyngeal) STI screening every 3 to 6 months
- However, performance on 3-site screening is not consistent across providers, resulting in less than optimal care for this vulnerable population.

SETTING

- The New York City Department of Health and Mental Hygiene (NYC DOHMH) funded Sexual and Behavioral Health (SBH) programs at 6 clinical facilities
- SBH programs provide holistic, co-located services to uninsured/underinsured HIV-negative MSM and other populations at risk, with the ultimate goal of preventing new HIV infections
- NYC DOHMH uses data submitted by the SBH programs to track key indicators of programmatic success and regularly provides reports to the funded programs to support data-driven technical assistance

Figure 1. Services Provided by NYC DOHMH-funded Sexual and Behavioral Health Programs

Service Type	Services Provided
Intake and Screening Services	• Medical and Psychosocial Assessment • Mental Health Screening • Substance Use Screening
Primary Sexual Health Services	• STI Screening and Treatment • Hepatitis Screening and Vaccination • HIV Testing Services • Pre-Exposure Prophylaxis (PrEP)
Emergency services	• Post-Exposure Prophylaxis (PEP)
Behavioral Health Services	• Brief Substance Use Counseling • Brief Mental Health Counseling
Supportive Services	• Health Education/Risk Reduction • Assistance with Social Services • Mental Health/Substance Use Referral

PROJECT

Project Goal

Increase 3-site STI screening for all MSM SBH clients through data-driven technical assistance

Project Timeline

November 2013: Performance indicators were introduced to SBH program administrators

- Included ***3-site STI screening indicators***: Proportion of MSM clients screened for STI at 1, 2 and 3 sites

June 2014: First ***biannual progress reports*** were provided to each SBH program

- Included aggregate (all SBH facilities) and facility-specific results for 3-site screening indicators were included (Figure 2)

February 2015: Began ***monthly quality assurance reports*** and ***monthly technical assistance calls***

- Reports documented monthly and year-to-date progress on 3-site STI screening indicators (Table 1)
- Calls included a discussion between DOHMH Project Officers (POs) and program administrators; sought to identify barriers to 3-site STI screening and potential solutions

Figure 2. Example of 3-Site STI Screening Indicators on Biannual Progress Report, Sexual and Behavioral Health Programs

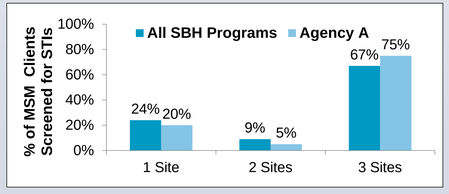


Table 1. Example of 3-Site STI Screening Indicators on Monthly Quality Assurance Report, Sexual and Behavioral Health Programs

MSM clients with STI screening, and at all three anatomic sites during specified time period	Year to Date		January 2015		February 2015	
	N	%	N	%	N	%
STI screenings conducted	253		29		34	
Screening conducted at 3 sites	216	85%	26	90%	29	85%

RESULTS

Patient Population

- Between October 2013 and December 2014, 1642 clients were enrolled in SBH programs
  - 57.2% (n/N=940/1642) identified as MSM
- Characteristics of MSM attending SBH programs shown in Table 1
  - 83.4% reported condomless sex in the past 12 months
  - 32.8% reported sex with an HIV-positive person

STI Screening Overall and by Site

- Majority of MSM (74.7%) received at least one STI screen
- 98.1% of STI screens included a urethral screen
- 73.1% of STI screens included an extragenital screen (pharyngeal and/or rectal)
- **66.3% had 3-site STI screening**

STI Screen Positivity Overall and by Site

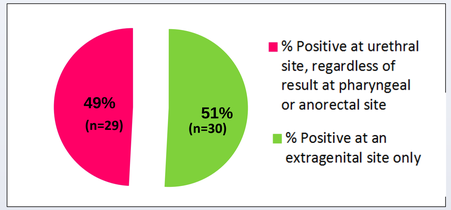
- Overall 8.4% of STI screens were positive (n/N=65/772)
- Among screens at multiple sites (urethral and ≥ 1 extragenital)
  - 10.7% (n/N =59/549) were positive at least one site
  - 2.4% (n/N=13/549) were positive at an extragenital site only
- Among positive s with multiple sites screened (urethral and ≥ 1 extragenital)
  - 50.8% (n/N= 30/59) were diagnosed at an extragenital site only (Figure 3)

Table 2. Characteristics of MSM Clients Enrolled in Sexual and Behavioral Health Programs, October 2013- December 2014

	n	%
Total	940	100%
Race/Ethnicity		
Hispanic	411	43.7%
Black, non-Hispanic	147	15.6%
White, non-Hispanic	285	30.3%
Other, non-Hispanic	97	10.3%
Age Group (years)		
< 24	227	24.1%
25-34	478	50.9%
35 or more	228	24.3%
Missing	7	0.7%
Sexual risk behavior in past 12 months		
Any condomless sex	784	83.4%
Sex with HIV-positive person	308	32.8%

RESULTS

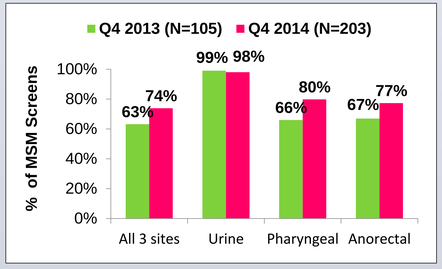
Figure 3. Site of STI Detection among MSM Screen Positives when Screening Was Performed at Multiple Sites (urethral and ≥1 extragenital), October 2013 to December 2014



Improvement in 3-site STI Screening

- Comparing Quarter 4 (Q4), 2013 to Q4 2014 (Figure 4):
  - 3-site STI screening increased significantly from 62.9% to 74.4% n/N=151/203) (p <0.01)
  - Significant increases were seen both for pharyngeal (p <0.01) and anorectal (p<0.05) sites

Figure 4. Proportion of Screens among MSM That Were 3 Site Screens and at Each Site, Quarter 4 (Q4) 2013 and Q4 2014



Time Period	Total Screens	3-Site	Urine	Pharyngeal	Anorectal
	N	n	n	n	n
Q4 2013	105	66	104	69	70
Q4 2014	203	151	199	162	157

RESULTS

Discussion of Barriers to 3-Site STI Screening

- Discussions on monthly technical assistance calls revealed barriers to 3-site testing:
  - Medical provider concerns about impact on patient flow
  - Perceived inconvenience to patients reporting exposure at fewer than 3 anatomic sites
  - Provider preference for presumptive treatment over preventive screening
  - Patient refusal of rectal screening
- This dialogue enabled DOHMH Project Officers to provide follow-up support and monitoring of measures to address barriers.

LESSONS LEARNED

- Routine reporting on clinical indicators was an important tool for focusing attention on key clinical priorities for MSM.
- Provision of indicators data facilitated data-driven TA, promoting optimal sexual healthcare for populations at high risk for HIV acquisition and transmission.
- Emphasis on performance for these contracted programs can serve to improve practice among providers more generally.
- Continuous communication between Project Officers and programs enhances program improvement.

SUMMARY AND NEXT STEPS

- Data-driven TA focused on 3-site STI screening indicators contributed to a significant improvement in provider delivery of 3-site screening for MSM
- We are applying this model of data-driven TA for SBH and other HIV prevention programs, including pre-exposure prophylaxis, to support improvements in sexual healthcare and HIV prevention for MSM

ACKNOWLEDGEMENTS

We would like to thank the funded clinical sites and their dedicated staff who support HIV prevention goals by delivering sexual and behavioral health services.