

EXPLORING SEXUAL HISTORY TAKING IN ONE HEALTH CENTER: A
FOCUSED ETHNOGRAPHY

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ABSTRACT

EXPLORING SEXUAL HISTORY TAKING IN ONE HEALTH CENTER: A FOCUSED ETHNOGRAPHY

Timothy Joseph Sowicz

Christine K. Bradway

Sexual history taking is the clinical practice of collecting information about patients' sexual health. Despite the availability of guidelines for conducting a sexual history, variability in the documentation of sexual histories exists. In addition to documentation, the literature on sexual histories is limited to their content, barriers to collecting them, and interventions to improve their documentation and health care providers' comfort and confidence in taking them. Additionally, the methods used to explore sexual history taking have been homogeneous. Absent from this literature is an in-depth understanding of the contextual factors affecting the collection of sexual history data as well as how health care providers evaluate and use sexual history data. To address these gaps in the literature, a focused ethnography of one health center was conducted. Guided by the theoretical perspectives of symbolic interactionism and the theory of culture care diversity and universality, data were collected primarily through passive observations of health care encounters between patients and health care providers and through individual interviews with health care providers. Over the course of approximately eight months of fieldwork, no specific sexual history taking was observed during health care encounters; this was likely influenced by the characteristics of the patients, communication between patients and health care providers, the prioritization of patients' basic needs, and time constraints imposed upon encounters. By using a methodology not previously employed

to study sexual history taking, this study adds to the evidence that sexual history taking may not routinely occur in a primary care practice setting. Given that the organization studied serves many patients who are homeless and who have concomitant mental health and opioid dependence concerns, the findings illuminate areas for future inquiry into a patient population at risk for adverse sexual health outcomes, and reinforces the need for routine sexual history taking.

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Chapter One: Introduction

Ms. Whelk

Ms. Whelk is a 40 year old self-identified female who was seen in the office last week for diabetes follow up. Ms. Whelk does not have stable housing and sometimes sleeps on the street. She does not always have access to food and often only eats one meal per day. Last week all of her medications were stolen while she slept in a shelter. During her most recent visit with her health care provider, she told the health care provider that she felt well overall, but noted that for the past week she had been having vaginal itching. The health care provider believed that she likely had a yeast infection given that her diabetes was grossly uncontrolled. The provider asked some additional questions about the vaginal itching and documented the following sexual history in the electronic health record (EHR):

Ms. Whelk is sexually active. Her first sexual intercourse was at age 15 years. She has sex with men only. She estimates that she has had seven partners in the past two weeks, and is not able to estimate the number of partners she has had in the past month, nor her lifetime. She does have one main partner, but has sex with other men in exchange for money and heroin. She has been intermittently injecting heroin for the past 10 years. She sometimes shares needles with her main sexual partner. She feels safe in her relationship with this partner but says that she has been physically abused by other men in the past, including being raped repeatedly as a child by a paternal uncle. She has oral and vaginal sex with all of her partners, and has anal sex with her main partner. She does not use condoms with her main partner but does with her other partners; however in the past year she has been forced twice by men giving her money to have vaginal sex without a condom. She says that she has had sexually transmitted infections (STIs) previously. She is unsure of the date of her last Pap smear. She recalls having an HIV test six months ago which was negative. She still gets her menses and had a tubal ligation five years ago.

With Ms. Whelk's permission the provider performed a pelvic examination and wet mount and diagnosed her with a yeast infection and trichomoniasis. A Pap smear and

cervical cultures for chlamydia and gonorrhea were obtained; similar cultures were obtained from Ms. Whelk's throat and anus. She had a negative urine pregnancy test in the office.

The provider gave Ms. Whelk: prescriptions for the medications to treat the vaginitis and for her stolen medications; laboratory tests for diabetes, HIV, hepatitis C, and syphilis; male and female condoms; discussed pre-exposure prophylaxis to prevent HIV infection; administered hepatitis A and B immunizations; and referred her to the social worker for assistance with housing and food. The provider also briefly discussed medical treatment for opioid dependence. The provider asked Ms. Whelk to return to the office in one week to discuss her diabetes, starting treatment for opioid dependence and HIV prevention. The provider asked her to speak to her partner about being treated for trichomoniasis and advised her to avoid unprotected sex with him until he had done so.

Following the encounter above the provider reviewed Ms. Whelk's EHR for the past year. She had been to the office on eight separate occasions in that time; mostly for follow up on diabetes, but also twice for treatment of skin abscesses on her arms. All of the previous notes contained little data about her presenting concerns. In some of those notes it was documented that Ms. Whelk did not use tobacco or drink alcohol; missing from all of the notes was her social history, including her sexual history. The notes for the visits where the skin abscesses were the presenting concern included mention that she occasionally injected heroin, but there was no documentation of education regarding the use of clean needles or routine screening for HIV and hepatitis C.

Statement of the Problem

The fictitious example above illustrates that sexual histories are not always documented, a finding supported by the literature. In studies where patients' health records were retrospectively reviewed for documentation of sexual histories, a wide range of rates of documentation exist. For example, among 25 adolescents with a life-limiting illness, none of their health records contained documentation of sexual histories (Sargant, Smallwood, & Finlay, 2014). Higher rates of documentation have been reported among adolescents in primary care. Banas et al. (2010) reported that 76% of 224 health records from adolescents in primary care included questions about sexual health. It is possible that data collected through chart audits do not accurately reflect the actual collection of sexual history data, as these discussions may occur more frequently than they are documented. However, low rates of discussions of sexual histories have been reported from audio-recorded patient-provider encounters. Ports, Barnack-Tavlaris, Syme, Perera, and Lafata (2014) reported that only 50% of 483 audio-recorded health maintenance visits included some discussion of sexual health, and only 10% of patients were asked if they were sexually active. However, a comprehensive sexual history can yield information that providers can use to minimize risks to sexual health (such as STIs or unwanted pregnancies) and individualize interventions to reduce risky behaviors. Sexual histories are a means for addressing other aspects of sexuality, such as sexual orientation, gender identity, and sexual pleasure (World Health Organization [WHO], 2006).

The provider above used the detailed sexual history to: 1) interpret how Ms. Whelk's behaviors and social situation (and those of others) were, or could potentially, impact her health; 2) diagnose the problems and treat them, and 3) develop a plan to

maintain her health and minimize her risk of adverse health outcomes. Since healthy individuals, as well as those living in high-risk situations like Ms. Whelk, may only interact with health care providers sporadically, each health care encounter presents an opportunity for health care providers to obtain sexual history data.

The Centers for Disease Control and Prevention (CDC, 2016) recommend that sexual histories be obtained during a patient's initial visit, during routine preventive visits, and when the provider sees signs of STIs. Within the guideline is a disclaimer that it is not a comprehensive reference for sexual history taking, and may need to be modified to be culturally congruent (CDC, 2016).

Given the low rates of sexual history documentation, it is important to understand when and how primary care providers collect sexual histories in daily clinical practice. Additionally, it is important to understand how providers interpret and use the data when providing care to patients, as the interpretation likely drives decisions about care.

Background

The recent literature on sexual history taking by health care providers has had broad foci in terms of purpose, but the characteristics of study samples and data collection methods has been narrow. This literature has been concerned with the content and documentation of sexual histories, interventions to improve both of these areas, and barriers to collecting sexual histories. In general, many of the studies have included data from physician providers from around the globe, where their education, training, and current scope of practice are not always defined. Data obtained from advanced practice registered nurses and physician assistants is scant and, for the most part, data collection

methods include questionnaires and health record audits, which fail to capture the day-to-day, practice-specific context in which discussions of sexual health occur.

Health care providers have identified barriers to initiating discussions about sexual health, including: gender incongruence between patients and providers, scarcity of time, the provider's personal beliefs and attitudes, and the lack of an effective treatment to address a particular sexual concern (Abdolrasulnia et al., 2010). Providers have also acknowledged that they are embarrassed by, or uncomfortable with, discussing sexual health with patients (Bray, McKenna, Sanders, & Pritchard, 2012). These barriers persist despite a body of literature including guidelines, expert recommendations, and data-based publications to assist clinicians with sexual history taking practices and procedures (Brook et al., 2014; CDC, 2015; Watts, 1979).

These barriers create missed opportunities for health care providers to assess the sexual health of patients. Subsequently, missed opportunities, although not causal, may lead to unwanted pregnancies, STIs, or the failure to address sexual satisfaction or dissatisfaction, or sexual functioning or performance. For example, in a case-control study of HIV infected (cases) and uninfected (controls) young African American men who have sex with men (MSM), the men who had not discussed HIV/STI prevention and screening with providers had higher odds of being infected with HIV (Dorell et al., 2011). Providers have acknowledged discomfort in dealing with certain patient populations, such as those identifying as gay and lesbian, injection drug users, and sex workers, and are less likely to obtain sexual histories from these people (Khan, Plummer, Hussain, & Minichiello, 2008). All of these groups have an increased risk of acquiring STIs, yet those charged with aiding in patients' health maintenance, including their

sexual health, feel uncomfortable discussing this aspect of patients' lives, leaving them uninformed and potentially vulnerable to the consequences of some of their sexual behaviors.

When sexual health data *are* queried, the content of the information gathered is variable. Across studies of sexual history taking practices there are inconsistencies in which components of the sexual history are included. For example, in some studies providers more frequently asked about condoms and other forms of birth control (Guerry et al., 2005), while in other studies providers more often asked about the number of sexual contacts (Do, Minichiello, Hussain, & Khan, 2015).

Regardless of which components of the sexual history are included, the rates at which they are routinely documented are low, even among high risk individuals such as female sex workers (Do et al., 2015) and MSM (Barber, Holland, Jenkinson, Spelman, & Stooze, 2011). Surprisingly, even when the presenting complaint includes symptoms of a STI, sexual history data are often not documented. In one study of 74 patients with symptoms of a STI, only 6 (8%) had a documented sexual history (Bangor-Jones, 2011).

In summary, the literature regarding sexual history taking is sparse, and primarily focused on the documentation and content of sexual histories, the barriers to taking sexual histories, and interventions to improve sexual history taking. Data from these studies have been collected mostly through questionnaires and chart audits. Few studies have examined sexual history taking using qualitative methods, including direct observation of patient-provider encounters. Such methods have the potential to discover unique factors contributing to low rates of sexual history documentation and the variability of their content.

Purpose of the Study

Patients have expressed a desire for health care providers to ask them about their sexual health; however, patients are often reluctant to initiate discussions about this topic (Hughes & Lewinson, 2014), and it has been reported that patients do not initiate conversations related to sexual health (Alexander et al., 2014). Given these findings, as well as the narrow focus of the existing literature on sexual history taking, it is important to understand broadly how sexual history taking occurs during clinical encounters; therefore the primary purpose of this study was to understand the sexual history taking practices of health care providers as they occur within the context of various health care encounters. Specifically, this study explored the following research question:

1. How do health care providers collect, evaluate, and use sexual history data during health care encounters with patients?

Theoretical Perspectives

The collection of sexual histories may or may not involve an interaction between patients and health care providers. For example, patients may provide information related to their sexuality and sexual health via self-report intake forms that may or may not be reviewed by health care providers; or in some clinical settings unlicensed staff may be responsible for collecting this information. Nevertheless, direct interaction between patients and health care providers, through verbal communication, is likely a more common approach to sexual history taking. The characteristics of such interactions may influence how, or if, sexual history data are collected, and these interactions occur within specific sociocultural contexts. Moreover, how health care providers evaluate the sexual history data they obtain, and decide to use it to render care or treatment are likely

influenced by the patient-health care provider interaction, and the context in which it occurs. To explore patient-health care provider interactions within specific sociocultural contexts, this study was informed by the theoretical perspectives of symbolic interactionism and culture care diversity and universality.

Symbolic interactionism.

Symbolic interactionism is concerned with the *meaning* of *things*, actions taken toward those things based on the meanings they have for humans, the derivation of the meanings of things through social interactions, and the management and adjustments to the meanings of things through interpretation by the person dealing with these things (Blumer, 1969). *Things* can be concrete objects, other humans, groups of humans, human activities, values, and institutions (Blumer, 1969).

For this study, sexual history taking (i.e., the elicitation of sexual history data from patients by health care providers) is considered the *thing* (i.e., a human activity). The meaning of sexual history taking likely varies among health care providers; some may view it as a tool for assessing risk for adverse sexual health outcomes while others consider it as an embarrassing task that they routinely avoid. Providers who inquire about patients' sexual histories gather information that can be used to maintain or enhance the patient's sexual health. Conversely, providers who do not perform sexual history taking (because of embarrassment or other reasons) are not able to assess patients' sexual health, nor address potential areas for intervention related to this aspect of patients' lives.

The theory of culture care diversity and universality.

Human beings interact within a sociocultural context. To understand the influence of this context on the sexual history taking practices of health care providers, researchers should consider the multiple factors influencing this practice. The purpose of the theory of culture care diversity and universality is “to discover, document, interpret, and explain the predicted and multiple factors influencing and explaining care from a cultural holistic perspective” (Leininger, 1997). These factors include worldview, cultural and social structure dimensions, environmental context, language, ethnohistory, generic and professional care practices (McFarland & Wehbe-Alamah, 2015).

Significance of the Study

Unlike previous studies that have focused on the content and documentation of sexual histories, this study is a broader exploration of sexual history taking within the context of a particular health care setting. While any health history taking is concerned with the collection of data, this study also aimed to examine how, or if, health care providers evaluate these data and use them in planning care for patients. By focusing on a previously un-examined area of scholarship, this study has the potential to address sexual history taking beyond simply the content and documentation of the phenomenon by providing an in-depth description of the context in which patients and health care providers discuss health-related information, in particular, sexual health. In addition, this study provides a foundation for what currently occurs in day-to-day practice and for future work in this important area.

Summary

This chapter introduced the state of the science regarding sexual history taking by health care providers, as well as the theoretical perspectives used to inform the study. The reasons for not obtaining sexual history data are numerous. These barriers likely create missed opportunities to discuss sexual health and sexuality, screen and treat STIs, and provide counseling about ways to reduce behaviors that can compromise patients' health. Much of our understanding of sexual histories has been derived from data obtained from physician self-report and chart audits, and has focused on the content and documentation of sexual history data. Missing from this literature is a description of how, or if, sexual histories are obtained in practice, how providers interpret sexual histories, and how they use data from sexual histories to inform decisions about screening, treatment, and education within the context of a particular practice environment.

In the next chapter I present in more detail the literature related to sexual history taking which is limited mostly to the content and documentation of sexual histories and the barriers to obtaining them in practice. I briefly discuss several interventions to improve sexual history taking. In chapter three, I discuss the method of inquiry used to answer the research question posed in this chapter.

Chapter Two: Review of Related Literature

Introduction

In this chapter, I synthesize the literature related to sexual history taking. The body of knowledge related to this area of inquiry is subdivided into four areas: the prevalence of documentation of sexual histories by health care providers; the content of sexual histories; barriers to sexual history taking; and tested interventions to improve aspects of sexual history taking. I also present a definition of sexual health, which is included to delineate it from other concepts with similar meanings, such as sexuality. An operational definition of this concept is important because sexual health is concerned with more than just the absence of disease. The chapter concludes with a summary and a brief introduction to the proposed method of inquiry, which will be presented in chapter three.

Recommendations for when to obtain, and what to include in, a sexual history exist for providers (Brook et al., 2014; CDC, 2016). The CDC recommends that a sexual history be obtained at patients' initial visits, during preventive health visits, and when signs of a STI are seen (CDC, 2016). Yet, rates of documented sexual histories have been low (Gongidi, Sierakowski, Bowen, Jacobs, & Fernandez, 2010; Maes & Louis, 2011). Providers have also reported that they would not routinely take a sexual history during a new patient's first visit (Barber et al., 2011; Lewis & Freeman, 1987).

The CDC recommends asking patients about their sexual *partners* and *practices*, *protection* from sexually transmitted diseases (STDs), *past* history of STDs, and *preventing pregnancy* (CDC, 2016). Similar to the CDC recommendations, other guidelines for sexual history taking focus on the prevention of disease and pregnancy and

do not explicitly guide providers to inquire about other aspects of sexuality, such as gender identity, intimacy, functioning, and pleasure (Brook et al., 2014). If any of the recommended domains of the sexual history are excluded, or if providers fail to ask any questions at all, then there is minimal to no information upon which providers and patients can draw to inform their decisions related to sexual health and behaviors.

For the purpose of this study, the World Health Organization (WHO, 2006) definition is used. Sexual health is:

A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (p. 3)

A broad understanding, such as the WHO definition of sexual health, is important to consider as the literature on sexual health is synthesized because concepts such as sexual health, sexuality, and sexual history may be defined differently (if at all), between studies.

Documentation of Sexual Histories

Health care providers may be familiar with the adage, “If it wasn’t documented, then it wasn’t done.” Health care encounters between patients and providers involve the exchange of information through nonverbal and verbal communication. For many reasons, including legal, financial, and continuity of care, the information shared during health care encounters is documented in patients’ health records by providers. While beyond the scope of this study, instances may occur where some aspects of an encounter are not reflected in what is found in the actual documentation of the encounter.

Despite the importance of health care encounter documentation, few studies have explored the documentation of sexual history data. Data collection methods, sample characteristics, definitions of sexual history, and the main findings of these studies are discussed below.

Data collection methods.

Appropriately, the documentation of sexual histories has been studied mostly through health record audits (Banas et al., 2010; Bangor-Jones, 2011; Holman, Carr, Baddley, & Hook, 2013; Loeb, Aagaard, Cali, & Lee, 2010; Loeb, Lee, Binswanger, Ellison, & Aagaard, 2011; Menon-Johansson et al., 2014; Sargant et al., 2014; Wimberly, Hogben, Moore-Ruffin, Moore, & Fry-Johnson, 2006). While this is an important means for exploring what health care providers are documenting in patients' health records, this method has limitations, and the notes that providers write may not accurately reflect the actual discussions of sexual health that occur (or do not occur) during encounters. Less frequently, studies have used provider self-report to explore documentation (Lanier et al., 2014). This method also has limitations, as providers may over- or underestimate their actual documentation practices. To explore what *actually* occurs during health care encounters, Ports et al. (2014) audio-recorded encounters and found that discussions of sexual health were low.

Sample characteristics.

Studies related to the documentation of sexual histories have involved adolescent and adult patients; examples include adolescents seeking emergency or primary care services (Banas et al., 2010), adolescents with a life limiting illness (Sargant et al., 2014), men with erectile dysfunction receiving care at a Veterans Health Administration facility

(Holman et al., 2013), persons diagnosed with chlamydia (Bangor-Jones, 2011), and MSM (Menon-Johansson et al., 2014). Other studies have explored documentation among more general populations, such as adults in primary care practices (Banas et al., 2010; Loeb et al., 2010; Loeb et al., 2011). Regardless of the characteristics of the patients, rates of documentation were found to be low.

Definitions of sexual history.

Although guidelines exist for the type of information to include in a sexual history, the operational definitions of sexual history varied between studies, and in one case was not clearly defined (Banas et al., 2010). In one study, only the documentation of discussions about anal or oral sex were explored (Menon-Johansson et al., 2014). In other studies, the authors operationalized the documentation of a sexual history as a notation of even just one sexual history component. For example, the authors of two studies defined sexual history documentation as the inclusion of just one of 18 components adapted from CDC guidelines (Loeb et al., 2010; Loeb et al., 2011). Similarly, Sargant et al. (2014) defined sexual history as “any documented reference to a sexual partner, sexual activity, STDs, or contraception” (p. 830). Other investigators required the notation of more than one component in their definition of a sexual history. For example, Bangor-Jones (2011) operationalized comprehensive sexual history as documentation of three or more of the following: safe sex, sexual practices, number of sexual partners, intravenous drug use, overseas travel, use of sex workers, or recent change in partner. While this gives the person extracting data an idea of things to look for in patients’ health records, other investigators have provided vague definitions of sexual history documentation, including any information on sexual activity (Holman et al., 2013).

While most investigators operationally defined sexual history, missing from these studies is an understanding of how individual providers define sexual history. For example, do providers ask all patients the same sexual history questions (or ask any questions related to patients' sexual health at all), or do they adapt their questions based on patient-specific characteristics (e.g., age, marital status, sexual orientation, other health issues or priorities)? Also absent from these studies is an understanding of the role that patients play in sexual history taking. Because the operational definitions of sexual health documentation varied between studies, it is difficult to compare overall rates of sexual history taking between samples; however, the rates were consistently low in individual studies.

Findings.

Among studies involving adults the rates of sexual history documentation vary. For instance, two studies reveal low rates of sexual history documentation among internal medicine residents in the U.S. In the first, the health records of patients seen for health maintenance visits by 25 internal medicine residents pre- ($N = 369$) and post-intervention ($N = 260$) were reviewed. Before the intervention, only 22.5% of health records per resident contained one or more components of a sexual history. Following the intervention, the prevalence increased to 31.7% (Loeb et al., 2010). In a second study, a review of 360 health records from outpatient health maintenance visits completed by 26 internal medicine residents revealed that only 25% contained documentation of a sexual history (Loeb et al., 2011).

Two other studies selectively sampled from patients with either erectile dysfunction or chlamydia. The health records of 240 men (ages 26 - 83 years) seen for

erectile dysfunction at a Veterans Health Administration facility revealed that only 3% ($N = 176$) contained sexual history documentation in the 12 months prior to being prescribed medication for erectile dysfunction. Furthermore, only 7% ($N = 240$) had documentation of a sexual history at the time the medication was initially prescribed, and only 5% ($N = 166$) at 12 months post when the initial prescription was written (Holman et al., 2013). Although sexual histories do not need to be collected during every health care encounter, the initial evaluation, ongoing management, and follow up of patients with disorders specifically affecting sexual health warrants the collection of at least some components of a sexual history. In the case of erectile dysfunction, such data are critical when investigating the underlying etiology, and as a means for discussing other preventive health screenings that may be related to the disorder (e.g., diabetes, cholesterol, hypertension).

In addition to functional problems affecting the genitourinary and reproductive systems of patients, infections that are acquired through sexual behavior can affect these and other body systems. Bangor-Jones (2011) reviewed general practitioners notes for adults who screened positive for chlamydia ($N = 486$), and only 9% contained three or more elements of a sexual history (this was the operational definition of sexual history in this study). It is important to note that not all of the patients included in this sample were symptomatic at the time they were screened. However, one would expect some documentation of a sexual history prior to screening patients for a STI.

In a study conducted in the United Kingdom, 6669 health records of asymptomatic women and men were audited to explore the documentation of anal and oral sex discussions (Menon-Johansson et al., 2014). The authors reported anal and oral

sexual discussions with MSM and women. Both anal and oral sex discussions were greater in MSM (91% and 92%, respectively) than in women (50% and 52%, respectively; (Menon-Johansson et al., 2014).

Two studies used questionnaires to collect data about sexual history documentation. The first involved 26 physicians, whose self-reported, mean number of documented sexual histories increased following an intervention (described in detail below) to improve this practice (Lanier et al., 2014). These self-reported behaviors were not verified by audits of health records. In the second study, 416 physicians self-reported the types of visits in which they take a sexual history. Over 75% reported that they take a sexual history if it is relevant to the presenting complaint; over half took a sexual history at an annual exam and at initial visits; and 1% reported never taking a sexual history (Wimberly et al., 2006). While it is important to have an understanding of documentation practices, what is more important is the content of sexual histories.

Content of Sexual Histories

Most of the literature on the content of sexual histories has been derived from questionnaires completed by providers (Gongidi et al., 2010; Guerry et al., 2005; Lewis & Freeman, 1987; Sobecki, Curlin, Rasinski, & Lindau, 2012; Tucker et al., 2012). Less commonly, data have been collected from patients' health records (Beckmann & Melzer-Lange, 2004; Loeb et al., 2010) and audio-recorded encounters (Ports, Barnack-Tavlaris, Syme, Perera, & Lafata, 2014). Across studies, the providers represent generalists and specialists who provide primary care services. Nurse practitioners and other advanced practice registered nurses are underrepresented in these studies, with nurse practitioners

included in only one (Guerry et al., 2005). The samples, data collection methods, and components of sexual histories from these studies are presented below.

The sexual histories reported by primary care providers contain similar and different components. Table 1 summarizes the components of sexual histories taken by primary care providers across four studies (Gongidi et al., 2010; Guerry et al., 2005; Lewis & Freeman, 1987; Sobecki et al., 2012).

Table 1

Content of Sexual Histories Taken by Primary Care Providers

Content	Gongidi et al., 2010	Guerry et al., 2005	Lewis & Freeman, 1987	Sobecki et al., 2012	Total
Marital status	X				1
Sexual orientation	X			X	2
Number of sex partners	X	X			2
Gender of sex partners	X	X	X		3
History of STIs	X				1
Contraceptive practices	X	X			2
Sexual satisfaction	X			X	2
Use of condoms		X			1
Sexual activity		X		X	2
Sexual practices		X	X		2
Sexual difficulties/problems			X	X	2
Sexual enjoyment/pleasure			X	X	2
Frequency of intercourse			X		1

Although it was the most commonly reported component, other authors have reported that they often fail to ask about same sex behaviors. For example, Tucker et al. (2012)

found that 76% of 62 physicians working in STI clinics in China, *rarely* or *never* asked patients about same sex behaviors.

These results of these four studies need to be interpreted cautiously as the components reported between studies may carry different meanings. For example, Guerry et al. (2005) reported the component, *use of condoms*, yet this may fall into another component reported in the studies by Gongidi et al. (2010) and Guerry et al. (2005), *contraceptive practices*.

In most cases, health record audits and questionnaires have been used to study the content of sexual histories; however, in a recent study (Ports et al., 2014), audio-recorded periodic health examinations between patients (ages 50 - 80 years) and family and internal medicine physicians ($N=64$) were studied to explore conversations regarding sexual health. Of the 483 audio-recorded encounters, sexual health was discussed in 47.1%; however, specific content areas important to sexual health varied. For example, only 10.5% of the recorded encounters contained a discussion of whether the patient was sexually active, and only 3.5% of the encounters included a discussion of the gender of the patient's current partner(s) (Ports et al., 2014). *Pap history*, *sexual performance*, and *STIs* were discussed more often (although still infrequently), in 20.5%, 18.2%, and 17.4% respectively (Ports et al., 2014).

Limited evidence exists that nurse practitioners inquire more frequently about certain aspects of sexual health than their physician colleagues. For example, Guerry et al. (2005) found that primary care nurse practitioners asked about the gender and number of patients' sex partners and about sexual practices (e.g., anal or oral intercourse) more frequently than primary physicians. Torkko, Gershman, Crane, Hamman, and Barón

(2000) reported that overall, nurse practitioners more frequently *always* or *often* took a sexual history than their physician colleagues. And more nurse practitioners than physicians routinely (i.e., *usually/always*) took sexual histories during annual, new patient, and acute care visits (Guerry et al., 2005).

The studies above demonstrate the variability in the content of sexual histories. And although guidelines for what to include in a sexual history are available to providers, a standardized method for sexual history taking may actually not be appropriate during all health care encounters. Lewis and Freeman (1987) stated, “Appropriate sexual histories, like any other area of history taking, do not involve asking the same detailed list of questions of all patients. More information is sought only as indicated by responses to previous questions” (p. 165).

Thus far, the literature on the documentation and content of sexual histories has been reviewed. Given the variability in both of these areas, it is important to understand why health care providers may not document sexual histories, and if they do, why certain questions are omitted. One explanation for this variability may be the numerous barriers that health care providers have identified to taking a sexual history in clinical practice. These barriers are reviewed below.

Barriers to Sexual History Taking

It is not surprising that health care providers are more comfortable discussing alcohol and tobacco use and exercise, than they are with issues like sexual orientation and practices (Bluespruce et al., 2001). The barriers to taking a sexual history have been well documented in the literature. Data from these studies have been collected through limited methods, including questionnaires and interviews. Unlike methods for data collection, the

participants who took part in these studies, were diverse in both professional roles and practice locations.

Following a review of eight qualitative studies conducted in the United Kingdom, a model of interwoven factors that influence providers' discussions of sexuality with adult patients has been developed (Dyer & das Nair, 2013). The types of factors are classified as structural factors, health care organization factors, and health care provider personal factors (Dyer & das Nair, 2013). Using this model, I describe the barriers to sexual history taking identified in the literature.

Structural factors.

Structural factors are those aspects of the broader society that health care providers have little control over, including the politics, economics, and overall organization of society (Dyer & das Nair, 2013). Two common barriers identified in the literature included in this category are interactions with certain types of patients and fear of embarrassing patients, which may be influenced by wider sociocultural norms.

Providers fear that they embarrass patients or perceive that patients are embarrassed by discussing sexual health (Barber et al., 2011; Do et al., 2015; Haley, Maheux, Rivard, & Gervais, 1999; Khan, Plummer, Hussain, & Minichiello, 2007; Lanier et al., 2014). In an effort to avoid making patients uncomfortable, providers may fail to take sexual histories. In doing so, they may overlook patients' concerns about sexual health or sexuality. And certain types of patients may be more at risk for this occurring.

Providers have identified that interacting with patients who have certain attributes is a barrier to discussing sexual health (Abdolrasulnia et al., 2010; Barber et al., 2011;

Bray et al., 2012; Gott, Galena, Hinchliff, & Elford, 2004; Gott, Hinchliff, & Galena, 2004; Haley et al., 1999; Khan et al., 2008; Maes & Louis, 2011). Age has been identified as one such characteristic. Several studies have reported that providers do not see the need to assess the sexual health of older persons (Gott et al., 2004; Gott, Hinchliff et al., 2004; Haley et al., 1999). Less commonly, providers have expressed concern about discussing sexual health with young people (Bray et al., 2012). Ironically, providers have identified the presence of parents or others in the exam room (or lack of privacy) as a barrier to discussing sexual health with young people (Bray et al., 2012; Khan et al., 2007; Kushner & Solorio, 2007; Lanier et al., 2014), yet they also fear being alone with patients (Bray et al., 2012). This may be related to another reported barrier: fear of being accused of sexual misconduct (Haley et al., 1999).

Individuals often have attributes that increase their risk for experiencing adverse sexual health outcomes (e.g., STI acquisition) and it has been reported that these attributes cause discomfort among health care providers. Men who have sex with men (Barber et al., 2011; Khan et al., 2008) and sex workers and intravenous drug users (Khan et al., 2008) are patients that make some health care providers uncomfortable. By avoiding discussions of sexual health, these types of patients are likely to be at even greater risk for adverse health outcomes, as well as increased stigmatization and marginalization.

Health care organization factors.

Individual health care organizations have their own norms, practices, and values which may influence discussions of sexual health between patients and providers (Dyer & das Nair, 2013). Lack of time was identified frequently as a barrier to discussing

sexual health across studies (Abdolrasulnia et al., 2010; Barber et al., 2011; Do et al., 2015; Haley et al., 1999; Khan et al., 2007; Lanier et al., 2014; Maes & Louis, 2011). Even if providers had more time with patients, many identified that they had inadequate training in sexual history taking and communication skills (Abdolrasulnia et al., 2010; Bray et al., 2012; Gott, Hinchliff et al., 2004; Haley et al., 1999; Maes & Louis, 2011). Other barriers were reported less frequently, including the lack of effective treatment for sexual problems (Abdolrasulnia et al., 2010), staff noncompliance with sexual history taking procedures and lack of reimbursement (Lanier et al., 2014), interruptions (Maes & Louis, 2011), and not being in a regular practice (Do et al., 2015).

Health care provider personal factors.

Personal factors include attitudes, knowledge, and motivations of individual providers as it relates to discussions of sexual health and sexuality (Dyer & das Nair, 2013). In some studies personal attitudes and beliefs were not defined (Abdolrasulnia et al., 2010). In other studies, providers' upbringing was discussed as a barrier, but was not further explained (Bray et al., 2012). Upbringing may encompass such things as religious beliefs and practices, or personal experiences such as having a parent who identified as being gay.

It is interesting to note that many of the barriers above have also been identified by trainees in the health professions. For example, medical students in Malaysia have identified similar barriers as those identified by practicing providers (Ng & McCarthy, 2002). To my knowledge, there have been no longitudinal studies that have reported on the changes in these barriers over time. However, there is a small body of literature on interventions to improve sexual history taking, which if incorporated into health

professional graduate education programs, may help to address some of the barriers identified in the literature.

Interventions to Improve Sexual History Taking

Investigators have developed interventions to improve the documentation of sexual histories and providers' comfort and confidence in collecting them. Some interventions involved role-playing and didactics (Loeb et al., 2010), while others used novel sexual history templates (Lanier et al., 2014). Some interventions involved physicians exclusively (Lanier et al., 2014; Loeb et al., 2010); others included graduate students in medicine and psychology (Blair, Arnow, Haas, & Millheiser, 2013; Ng & McCarthy, 2002); and others involved nurses and physicians (Calamai, Howard, Kelly, & Lambert, 2013). A brief description of each intervention follows.

Interventions to improve documentation of sexual histories.

Loeb et al. (2010) implemented a teaching intervention to increase the documentation of sexual histories among a sample of 25 internal medicine residents in the U.S. The intervention consisted of three, 30-minute teaching sessions that addressed: 1) the significance of a sexual history, 2) sexual history taking precepts, and 3) role-playing (Loeb et al., 2010). Prior to the intervention, 17.1% of the health records reviewed ($N = 369$) included the component, *whether patient is sexually active* (Loeb et al., 2010). Following the intervention, this component was found in 20.7% of the health records ($N = 260$; (Loeb et al., 2010)). The health records pre- and post-intervention were audited for documentation of 18 components of a sexual history, all of which increased post-intervention; however, even following the intervention the rates of 16 of the 18 components were below 10% (Loeb et al., 2010).

Lanier et al. (2014) also implemented an intervention to improve sexual history documentation. Participants in this study attended either a one-time, in-person or webinar sexual history training, which “included background information about HIV/STI epidemiology, sexual history demonstrations, and physician-patient sexual history roleplaying (onsite only)” (p. 114). Participants included 26 family, internal, and adolescent medicine physicians, pediatricians, and general surgeons (Lanier et al., 2014). Twenty-one physicians attended the on-site session and five attended the webinar. Of the 26 physicians, the mean number of estimated sexual histories that were documented per month increased from 60 at baseline to 114 at the post-training follow-up (i.e., 1 – 3 months post-training; (Lanier et al., 2014)). These investigators also reported that there were increases in the number of routine sexual histories conducted with male patients (75% at baseline; 100% at follow-up) and that these were documented in their health records (60% at baseline; 92% at follow up; (Lanier et al., 2014)). These data were collected through questionnaires completed by the participants pre- and post-training, and documentation was not verified by reviewing health records.

Interventions to improve health care provider comfort and confidence in taking sexual histories.

Interventions have been designed to increase providers’ comfort with eliciting a sexual history. A communication skills intervention was tested with 198 medical students in Malaysia to teach sexual history taking, including how to discuss sexual health issues with patients. The intervention lasted 1.5 hours and involved a brief lecture, role-playing, and discussion of the role-playing exercises (Ng & McCarthy, 2002). Attendees completed pre- and post-intervention questionnaires. The pre-intervention questionnaire

explored participants' comfort in talking to patients about sex. *Comfort* was assessed using a Likert scale (1=feeling very uncomfortable; 5=very comfortable; (Ng & McCarthy, 2002). Participants' mean comfort level with discussing sex with patients increased following the intervention (2.60 pre-intervention; 3.75 post-intervention; $p < 0.001$ (Ng & McCarthy, 2002).

As part of an experimental study utilizing a pretest-posttest design, and involving an educational intervention for assessing and managing women's sexual complaints, Blair et al. (2013) explored participants' comfort discussing sexual health with patients, "including taking a thorough sexual history" (p. 536). Participants included 59 mental health and medical providers and graduate students in medicine and psychology (Blair et al., 2013). The intervention included a lecture on female sexual dysfunction, and the barriers to treating these problems encountered by providers. Participants completed a sexual history inventory, observed the taking of a sexual history (between the two presenters – a medical director (not otherwise defined) and a doctoral student in clinical psychology), and practiced sexual history taking in pairs (Blair et al., 2013). Results from pre- and post-intervention questionnaires identified improvements in mean scores for several variables related to sexual history taking post-intervention. For example, *discussing sexual history with my patients is very important* had a pre-intervention mean of 4.04, which increased to 4.72 post-intervention ($p = 0.00$); *I am comfortable talking with my patients about their SH* had a mean score of 3.43 before the intervention, and a mean score of 4.00 ($p = 0.00$) following the intervention; and the pre-intervention mean for the item, *I am comfortable taking a sexual history* was 2.93, which increased to 4.02 following the intervention ($p = 0.00$; Blair et al., 2013). A scale for scoring answers to

these questions was not explicitly discussed, but the reader can deduce that smaller numbers indicate less comfort, while larger numbers indicate more comfort based on the results section. Neither the interventions by Blair et al. (2013) or Ng and McCarthy (2002) explored how these increases in comfort impacted the documentation of sexual histories.

Related to comfort in sexual history taking is providers' confidence that they can actually take a sexual history, and have the means to do so. Calamai et al. (2013) explored how screening for, and management of, STIs were affected by attending an educational course focused on the management of STIs. Also explored were confidence and ability in, and technique for, sexual history taking. Participants included 48 Irish general practitioners and public health physicians, five nurses, and two others (whose professions were not explicitly reported). The British Association for Sexual Health and HIV (BASHH) developed the Sexually Transmitted Infections Foundation (STIF) Course, which was designed to provide information about the management of STIs. The authors did not discuss the course in detail, but did provide a reference for the course manual (Calamai et al., 2013). Among participants ($N = 55$), 83.6% and 72.7%, respectively, self-reported improved: 1) confidence and ability in taking a sexual history, and 2) technique for obtaining a sexual history following course participation (Calamai et al., 2013). It should be noted that for both findings, participants chose from one of two responses (i.e., *improved* or *not changed*). Therefore, more than a quarter of the study participants reported that their technique had not changed following the intervention. Also, *change* was not operationally defined, and this concept could have different

meanings for individual participants. This was not a longitudinal study, and whether the improvements in technique were sustained over time could not be ascertained.

The interventions described in this section demonstrated positive effects for specific interventions of sexual history taking; however, with the exception of the study by Ng and McCarthy (2002), all had small sample sizes, were comprised mostly of physicians, and primarily employed pretest-posttest designs with pre-selected answer options. The study with the largest sample size was composed of medical students (Ng & McCarthy, 2002), but the experiences of students may be fundamentally different than independently practicing providers. Other participants across samples were graduate students in psychology and mental health providers (Blair et al., 2013), and nurses (Calamai et al., 2013). In one study, the profession(s) of some participants were not stated explicitly (Calamai et al., 2013). None of these interventions included advanced practice registered nurses.

Summary

Our understanding of sexual history taking is currently limited to investigations of the content and if, or how a sexual history is documented in a patient's health record. A substantial literature reveals low documentation rates, wide variations in content, and identification of primarily provider-acknowledged barriers to sexual history taking. To date, the overwhelming majority of study participants have been physicians, in mostly Western Europe and North America; studies conducted among providers in Africa and Central and South America are completely absent. Few studies have included advanced practice registered nurses, and those that have are limited to nurse practitioners.

For those studies exploring sexual history documentation and content, and barriers to sexual history taking, data collection occurred mostly through health record audits and questionnaires completed by physician providers. Interventions to improve sexual history taking have mostly utilized pre- and post-test designs, and have had small sample sizes, the results of which are likely not generalizable to all physicians and other non-physician providers.

To expand the body of knowledge on sexual history taking I conducted a focused ethnography at one primary care practice. The use of ethnography was a unique method for studying this particular clinical practice behavior; I was able to identify many contextual factors likely influencing the health care providers' sexual history taking practices. In chapter three I discuss in detail the method of inquiry used to explore the research question posed in chapter one: How do health care providers collect, evaluate, and use sexual history data during health care encounters with patients?

Chapter Three: Method of Inquiry

Introduction

In the previous chapter, the gaps in knowledge related to sexual history taking were uncovered: recent studies have been limited to only a few areas of inquiry, such as the content and documentation of sexual histories; data collection methods were limited to mostly questionnaires and health record audits; interventions used a pre-test/post-test design; and non-physician providers were underrepresented in samples. Interestingly, the barriers to sexual history taking were similar across studies that have been undertaken in different geographic locations. To explore sexual history taking during actual patient-health care provider encounters this study employed a qualitative, interpretive design. Included in this chapter is a discussion of the design, as well as the setting, informants, and procedures for data collection, management, and analysis. I also discuss study rigor and trustworthiness, and methods for protecting the human informants involved in the study. The chapter concludes with a summary and an introduction to the study findings.

Design

In an effort to gain an integrated understanding of sexual history taking within the context of varied health care encounters, an interpretive, focused ethnographic research design was utilized. Muecke (1994), in writing about the evaluation of ethnographies, proposed two broad categories of ethnographies: health sciences ethnography (i.e., focused ethnographies) and anthropologic ethnographies, which she further subdivided into classical, systematic, interpretive, and critical ethnographies. She contrasted the two categories on several components, including purpose and how participant observation is

conducted. Although many definitions of ethnographies exist, for the purpose of this study, I used Muecke's (1994):

An ethnography is a written description of a people that focuses on selected aspects of how they lead their routine, remarkable, and ritual lives with each other in their environment, and of the beliefs and customs that comprise their common sense about their world. (pp. 189-190)

She also provides a more specific definition of focused ethnographies:

Time-limited exploratory studies within a fairly discrete community or organization. They gather data primarily through selected episodes of participant observation, combined with unstructured and partially structured interviews. The number of key informants is limited; they are usually persons with a store of knowledge and experience relative to the problem or phenomenon of study, rather than persons with whom the ethnographer has developed a close, trusting relationship over time. (Muecke, 1994, p. 199)

A focused ethnography is an appropriate design to study how health care providers collect, evaluate, and use sexual history data during healthcare encounters within the context of a single primary care practice; it directly engages the researcher with patients and health care providers in settings where this practice behavior is most likely to occur. This interpretive, ethnographic design is novel for studying sexual history taking, which has traditionally been explored and described quantitatively by data gathered from health record audits and self-reported responses to questionnaires by providers, most of whom have been physicians.

Setting

The Liberty Health Center (LHC; a pseudonym) is a federally qualified health center (FQHC) located in a city in the northeastern region of the United States of America. A comprehensive description of the LHC is provided in chapter four. The term *health center*, within the Public Health Service Act, is defined as,

An entity that serves a population that is medically underserved, or a special medically underserved population comprised of migratory and seasonal agricultural workers, homeless, and residents of public housing, by providing, either through the staff and supporting resources of the center or through contracts or cooperative arrangements - (A) required primary health services...; and (B) as may be appropriate for particular centers, additional health services...necessary for the adequate support of the primary health services...For all residents of the area served by the center (U.S. Department of Health and Human Services [HHS], 2016c).

According to the National Association of Community Health Centers (2016), more than 24 million Americans receive primary care services at FQHCs, many of whom are uninsured. Given the large number of people served by FQHCs (a number likely to increase following the passage of the Patient Protection and Affordable Care Act), they are an ideal setting to explore the sexual history taking practices of providers who encounter patients from a variety of sociocultural backgrounds. Perhaps not unlike privately owned primary care practices, FQHCs tailor the care they provide to the needs of the communities they serve (Anderson & Olayiwola, 2012).

Procedures

Gaining entrée.

The process for gaining entrée to the LHC was circuitous, and began in October 2014. As I was unfamiliar with the FQHCs in the area in which I wanted to conduct this study, I contacted a primary care nurse practitioner colleague who was familiar with various practices in the area. She introduced me via email to a former health commissioner, who then introduced me to the chief executive officer of a network of various health centers in the area, whom I met in person in the autumn of 2014 to discuss my research. She, in turn, introduced me to the executive director of a specific network of community health centers in the area, whom I met with in person shortly thereafter.

During that meeting I explained my background as a family nurse practitioner at a FQHC, as well as my research interests and topic for my dissertation research. I was given a brief tour of one of the health centers and the executive director introduced me via email to two nurse practitioners who provide care for patients at different sites and were employed by the organization. After several attempts to contact these providers to arrange in-person meetings, they ultimately decided that they, and the organization, would not be able to accommodate my research.

I again contacted the chief executive office of the larger network of health centers (whom I was introduced to by the former health commissioner) who sent me the names of other contacts who might be interested in participating in the study. At the same time, I contacted the LHC. I had previously met two of its staff, the ambulatory care manager and a social worker, at a symposium on homelessness. I sent a brief description of my study to the ambulatory care manager. Just over a week later I received a response from her indicating that the medical director granted permission for me to conduct the study at the LHC. I then obtained a letter of support from the chief executive officer/executive director of the LHC after speaking with her on the telephone. During the call I described the study and answered her questions. I have chosen not to include a copy of the LHC's letter of support in this dissertation to protect the confidentiality and anonymity of the organization and its staff; however a copy was submitted to the University of Pennsylvania Institutional Review Board (IRB).

I kept in contact via email with the ambulatory care manager and chief executive officer/executive director of the LHC periodically during the interval when my research proposal was being evaluated by the University of Pennsylvania IRB. At the beginning of

May 2015 I met with several LHC staff members on-site to discuss the study and answer their questions. Several staff in attendance were interested in participating in the study. I began my fieldwork on May 28, 2015.

Informants.

Health care providers, patients, and other staff at the LHC served in some way or another as informants for the study. When I began my fieldwork, I envisioned that the key informants would be the medical professionals (i.e., two physicians, one physician assistant, and one psychiatric nurse practitioner) because they provide primary care services and have training in sexual history taking. These providers are licensed to diagnose and develop plans of care for patients who have an identified, or potential, concern related to their (sexual) health. As a new research question emerged during my fieldwork (I discuss this in chapter four) I expanded my conceptualization of *health care provider* to include any staff member that afforded a service to patients at the LHC, not just medical care. For example, social workers and a peer advocate were interviewed as part of data collection. Interviews with individual informants are discussed in more detail later in this chapter and in chapter four.

I did not interview or obtain written consent from patients for this study. Patients provided verbal permission for me to observe their encounters with the health care provider I was following on that particular day and as a result, my observations of patients were dictated by the health care providers' schedules. Informants were excluded if they did not wish to have me observe their health care encounters (patients) or aspects of their work (health care providers), or if the provider advised that I not participate in a

particular health care encounter. In chapter four I describe the encounters that I did not observe and the reasons for not doing so.

Data collection.

Informant characteristics. Using a standard form (see Appendix A) I collected minimal demographic data from the informants. These data included name, professional title, highest level of education, years in clinical practice in their current role (e.g., as an advanced practice registered nurse), and years in practice at the LHC. Informants, or I (with their permission), completed this form prior to participating in an audio-recorded semi-structured interview. Informants were offered an opportunity to create a pseudonym (first name only); many chose not to do so and instead used their legal first name.

Deception/incomplete disclosure. The purpose of this study was to explore sexual history taking. In planning the study I considered that providers may alter their behavior around this area of history taking if they knew that I was specifically exploring the sexual history component; therefore I told informants (and this was written in the consent form) that the purpose of the study was to “learn more about how health care providers collect, evaluate, and use health history information during the course of health care encounters with clients/patients.” My research findings were presented to the informants and other stakeholders of the LHC following the completion of the study. At that time I disclosed that my original research question involved exploring sexual histories specifically. The use of deception/incomplete disclosure was approved by the University of Pennsylvania IRB. The chief executive office/executive director of the LHC was also aware of my use of deception/incomplete disclosure at the outset of the study.

Passive observation. Data collection occurred primarily through passively observing health care encounters between patients and providers. This was an appropriate approach because the study was concerned with a specific aspect of patients' health histories that are collected/assessed within the context of patients' visits. My observations of patient-health care provider encounters are described in detail in chapter four.

Situational conversations. Schatzman and Strauss (1973) defined situational conversations as "on-the-spot questioning when unsolicited verbalization as well as observations confound him [the investigator]" (p. 71). Opportunities for such brief conversations occurred with informants throughout my fieldwork. These conversations were used to clarify questions that I formulated from observations during encounters, or to understand processes and procedures specific to the LHC. I did not interrupt patients or health care providers during health care encounters to have these conversations. These conversations were not audio-recorded, but I took notes on them.

Semi-structured interviews. Following a period of time in which I passively observed multiple health care encounters involving a variety of providers, and collected notes on my situational conversations with informants, I conducted semi-structured interviews with twelve informants. An IRB-approved interview guide (see Appendix B) was created following a review of my field notes. The questions focused on providers' role and typical work days at the LHC, philosophies of care, ideal ways for providing care, types of patients, building and maintaining relationships with patients, interactions with co-workers, and approaches to differing types of visits. Of note, I created an interview guide (see Appendix C) prior to beginning data collection which covered the major domains of my research question: the collection, evaluation, and use of sexual

history data. Given the inductive nature of this research, and ongoing data analysis, this guide was abandoned and replaced with the one described. This change is further described in chapter four.

Field notes. Field notes are a record of the investigator's observations and impressions (Schatzman & Strauss, 1973). Field notes can be classified as observational notes, theoretical notes, or methodological notes. Observational notes record events experienced through observation and listening and include little interpretation. Theoretical notes record the investigator's meaning making from her or his observations. Methodological notes are observational notes of the investigator herself or himself (Schatzman & Strauss, 1973). I recorded all three types of notes throughout the course of my fieldwork. I refrained from taking notes during observations of health care encounters. Rather, following each encounter I wrote brief notes by hand in a field journal; these notes were then reread after leaving the LHC and typed using word processing software.

Data management.

My field journal and additional paperwork (e.g., collected artifacts and signed informed consent forms) remained with me at all times during fieldwork. Following each fieldwork experience these papers (as well as my digital audio recorder and external hard drive) were secured in a waterproof and fire resistant locked box. Interviews were digitally audio recorded and transcribed verbatim by a professional transcriptionist. All field notes and transcripts of interviews were uploaded into Dedoose (<http://www.dedoose.com>), a web-based data analysis program, which uses encryption technology and is password protected. My laptop computer is also password protected.

Copies of transcribed interviews and field notes were also saved on an external hard drive.

Data analysis.

Data analysis occurred as a continuous process, beginning on the first day of passive observation and ending when all data were collected and analyzed. Leininger's Phases of Ethnonursing Data Analysis Enabler for Qualitative Data was used to inform the ongoing and final data analyses (Wehbe-Alamah & McFarland, 2015b). The four phases are 1) *collecting, describing, and documenting raw data (use of field journal and computer)*, 2) *identification and categorization of descriptors*, 3) *pattern and contextual analysis*, and 4) *major themes, research findings, theoretical formulations, and recommendations* (Wehbe-Alamah & McFarland, 2015b).

Throughout the process of data collection and analysis I met regularly with my dissertation committee to discuss my data and my emerging findings. My dissertation committee had access to my transcribed interviews and field notes. I also discussed data collection and analysis with members of the Advanced Qualitative Collective (AQC). The AQC is a group of pre- and post-doctoral fellows, as well as a member of the standing faculty of the School of Nursing, who are committed to gaining deeper understanding of naturalism and diverse qualitative methods. Members of the AQC provided feedback as I created a revised interview guide and discussed my preliminary findings. Given the dynamic nature of ethnography I have found it fitting to blend specific details of data analysis with the findings of the study; therefore data analysis is described further in chapter four.

Qualitative Criteria to Evaluate the Study

Several strategies were used to ensure rigor. The first two strategies were prolonged engagement in the field and persistent observation (Morse, 2015). I conducted field work, including observations and individual interviews, over approximately eight months. Although I had previously met some of the LHC staff prior to beginning fieldwork, this extended amount of time in which I was able to learn more about the organization, observe individual and group behaviors, and speak in depth with key informants lent itself to the development of trusting relationships. These two strategies are foundational for producing a thick, rich description, the third strategy used to establish rigor (Morse, 2015). As a result of my presence at the LHC over a substantial period of time and willingness to participate in experiences that I did not initially plan to be involved with (e.g., observing outreach work and offering to assist in the move to the new building) trust between the informants and myself was enhanced. This likely contributed to informants' interest and enthusiasm for being interviewed, as well as being candid and quite reflexive during individual interviews. An example from my fieldwork was that Carol, the psychiatric nurse practitioner, did not initially want me to observe her encounters with patients. Over time she would seek me out to discuss some of her encounters and eventually welcomed me to observe them as well as interview her.

A fourth strategy used to establish rigor was triangulation of several data collection methods (Morse, 2015). Data from this study were collected by several means: passive observations at the LHC and during patient-health care provider encounters, individual interviews with informants, situational conversations, and field notes. An example is that data from passive observations were used to create a revised interview

guide which was used during individual interviews. Reviewing artifacts, such as the poster reporting the number of Pap smears performed at the LHC, were used to inform other methods for data collection. Triangulation expanded the breadth and depth of the study as different types of data were collected from each method (Morse, 2015).

The final strategy for establishing rigor in this study was peer review/debriefing (Morse, 2015). As discussed I consulted with my dissertation committee and the AQC before, during, and after the collection of data. These meetings were opportunities to present my ideas and findings, accept constructive critique, and discuss data analysis. One reason for using peer review/debriefing is to minimize bias (Morse, 2015). An example of this is that early in data collection I observed that providers asked few questions about the presenting concerns and did not always perform a physical exam; I was comparing my practice as an advanced practice registered nurse with the practices of the informants. I was able to discuss this concern (and its potential impact on subsequent data collection), acknowledge my bias, and appreciate that there were different ways to approach encounters with patients that I was unaccustomed to.

Human Subjects Considerations

Permission to conduct fieldwork.

I obtained verbal and written permission from the chief executive officer/executive director of the LHC to conduct this study. The University of Pennsylvania IRB approved this study (see Appendix D).

Informed written consent, verbal permission, and assent.

Informed written consent was obtained from informants prior to each semi-structured interview (see Appendix E). To my knowledge, no physical, psychological,

social, or financial harm befell any informants. In observing the behaviors of clinicians I was aware that some may be wary that I would critique their individual practice styles and behaviors. I explained to informants that while I was passively observing behaviors around history taking, the data that I gathered would not be used to describe individual practice behaviors, nor would I discuss the practices of individual providers with their colleagues or supervisors. I assured them that all data would remain confidential, and no identifying information (other than their chosen pseudonyms) would be linked to field notes or interview transcripts.

While I did not offer financial compensation to informants, I explained that the study had the potential to inform clinical practice regarding health history taking that may ultimately lead to improvements in such practices, as well as improved use of the data collected from such health histories, which in turn may enhance the care provided to patients by increased screening and more comprehensive consideration of individual patient needs. I made explicit that participation was voluntary and informants may withdraw from participating in the study at any time. I provided all informants with my email address and mobile telephone number and encouraged them to contact me with any questions or concerns related to the study. During the course of the study, one informant who I had interviewed was terminated before I provided her with a copy of her informed consent form. I placed a paper copy of her consent form in a stamped envelope and provided it to the LHC's manager of operations, who assured me that it would be mailed to the informant. All other informants were provided a copy of their consent forms electronically.

I explained to the informants who were not interviewed (e.g., patients and other LHC staff) my role as an investigator within the organization and obtained verbal permission to observe their health care encounters (patients) and role-specific responsibilities (other LHC staff). I spoke to the chief executive officer/executive director of the LHC regarding the issue of consent from patients, who confirmed that I did not need to obtain written consent from them; rather, verbal permission would be sufficient (this was approved by the University of Pennsylvania IRB). I did not observe health care encounters in which patients did not provide verbal permission.

I was aware that during fieldwork there was the potential to encounter patients deemed vulnerable, including children and pregnant women; however none of the encounters that I observed over the course of data collection involved such individuals. I had an IRB-approved assent form (see Appendix F) available with me at all times during fieldwork in case I observed encounters with such individuals.

Anonymity and confidentiality.

The anonymity and confidentiality of informants were maintained by using pseudonyms, which were chosen by the informants. Some informants chose to use their actual names. As previously described, all paper copies of informed consents, field notes, informant characteristic forms, and artifacts with the name of the organization affixed were kept in a locked box. Electronic copies of these forms, as well as transcribed interviews were stored on an external hard drive and/or in Dedoose, a web-based data management application that is encrypted and password protected. This electronic information was only accessed from password-protected computers.

Summary

In this chapter I described the method of inquiry for the proposed study; specifically I discussed the research design and its appropriateness for studying sexual history taking. I introduced the setting and methods for data collection, management, and analysis, all of which will be examined further in chapter four. The chapter concludes with the presentation of the considerations undertaken to protect the informants who participated in the study and the strategies that were used to establish rigor.

Chapter Four: Findings

The Collection, Evaluation, and Use of Sexual History Data in the LHC

The original purpose of this study was to explore how health care providers collect, evaluate, and use sexual history data in the context of patient-provider encounters. To assess sexual health, the CDC (2016) recommends including a discussion of a patient's sexual partners and practices, protection from and past history of sexually transmitted diseases, and preventing pregnancy. Using this as a specific template for what a sexual history could or should include, I did not observe any of the providers collect this data from patients over the course of my fieldwork. Additionally, I did not observe the collection of other aspects of sexuality frequently cited or recommended in the biomedical literature or in published guidelines, such as sexual orientation, gender identity, and sexual satisfaction (Brook et al., 2014; CDC, 2016); however, there were instances in which a broader perspective or some aspect of sexuality was observed or discussed during one on one interviews and these findings are incorporated into the overall findings in this chapter.

A new question emerges.

Following a period of fieldwork (just over two months) in which data were collected primarily through passive observations of patient-provider encounters, and in which I observed no specific sexual history data being collected, an additional research question emerged: *What historical data are being collected, evaluated, and used in the context of the LHC?* To begin exploring this question, I reread all of my field notes to date and wrote a memo summarizing my observations. Based on this memo I began theorizing about why I had not observed sexual histories as defined above, and started to

consider a deeper examination of what actually *was* happening during patient-provider interactions in this setting.

To understand my observations in the context of the LHC I decided that it was an appropriate time to begin conducting semi-structured interviews with key informants. As previously described in chapter three I initially created an interview guide in which the questions focused on the collection, evaluation, and use of sexual history data (see Appendix C). As fieldwork progressed, I used initial observations to reframe the focus of individual interviews and developed an IRB-approved interview guide which focused on more general concepts: the characteristics of the patients and the providers, the provision of care, and building and maintaining relationships (see Appendix B). The individual, semi-structured interviews I conducted will be discussed in more detail in this chapter. What follows is a description of the LHC which builds upon the introduction to it in chapter three. I then discuss the fieldwork I conducted, including the number of, and reasons for, patient-provider encounters. This is followed by a description of encounters in which some aspect of sexuality was mentioned. The chapter concludes with a discussion of my individual interviews and the presentation of the main findings which provide an in-depth description of how the LHC provides primary care (and other services) to a highly vulnerable and at-risk patient population.

The Liberty Health Center

In 2014 the LHC provided care to more than 2,800 individuals, the majority of whom were adults (i.e., 18 – 64 years). Most of these individuals were at or below 200% of poverty and received Medicaid/CHIP benefits; almost 14% were uninsured and almost 80% were homeless. The LHC offers medical, mental health, substance abuse, and

enabling services (e.g., case management, transportation, and outreach). I have not included a reference for these data (which are publicly available given that the LHC is a federally funded health center) to protect the anonymity and confidentiality of the organization and its staff.

The LHC employs four providers with prescriptive authority (i.e., one physician assistant, one psychiatric nurse practitioner, and two physicians), and all are qualified to take sexual histories. Other providers include three medical assistants, an ambulatory care manager (a registered nurse), a clinical care registered nurse, two social workers, and a variety of other professionals such as billing and reception clerks and financial counselors. Overall it is a relatively small organization, but has been growing. As the ambulatory care nurse manager noted, “When I first started I think we were under 20 staff members and now we’re closer to 30.”

When I began fieldwork the LHC was housed in a single floor building. The exterior of the building was plain and it appeared to be an older building, but I would not describe it as rundown. The waiting area contained some chairs, and posters displayed health information for visitors. These posters presented information on a variety of topics, including colorectal cancer screening, mental illness, summer health risks, and HIV/AIDS awareness. There was a television mounted on the wall and a water cooler was available. The waiting area was separated from the clinical area by a hallway; halfway down was a reception desk which is the first thing a person would encounter when walking through the front door. The area beyond the reception desk was composed of a small staff lounge, a place where some staff members ate lunch. There were four examination rooms which doubled as a space to interact with patients as well as an office

for the provider. Each of the four health care providers (i.e., two physicians, one physician assistant, and one psychiatric nurse practitioner) had a designated examination room/office. Typically the examination rooms/offices contained a desk, two chairs, a rolling stool, and an examination table. Various other supplies were located in these rooms as well, some of which were expired. Other offices in this clinical area were occupied by the ambulatory care nurse manager and the two social workers. There were also two storage rooms in this area. A sign with the word, “Phenomenologists” hung on the door of the social workers’ office. The clinical care registered nurse’s office was closer to the reception desk. Electronic equipment to take patients’ vital signs and a scale were kept in the hallway outside of the rooms and offices. All of the rooms and offices were in close proximity to each other; staff in this area only needed to walk across a narrow hallway or into an adjacent room to see or interact with each other.

Prior to the start of fieldwork I was aware of the plan to transition the practice into a new building, currently being constructed next door. A few months after beginning fieldwork, and after several delays, the transition to the new building was completed. The old building has since been demolished and a parking lot sits on the site of the former home of the LHC. Unlike the old building the new one has two stories; the administrators have offices on the first floor and the clinical areas are located on the second floor. Also on the first floor are offices for the providers and other staff as well as a small kitchen area, staff bathrooms with showers, and a much larger staff lounge space. Unlike the old building, all of the providers share office space; they do not have individual offices. Most of the providers congregate in this area in the morning prior to seeing patients upstairs.

Another change ushered in with the opening of the new building is the on-site presence of the administrative staff, including the chief executive officer/executive director. When the LHC was housed in the old building, the administrators' offices were located off-site. I did observe the chief executive officer/executive director in the old building periodically before the move; however, for the most part the administrators remained on the first floor in the new building. Once I did observe the chief executive officer/executive director escorting a contractor around the new building, pointing out changes that needed modification following the move. A desk where the security officers sit is located at the main entrance of the new building, just off the parking lot. There is elevator access to the second floor.

The new building is shaped like a "L." One the second floor one side of the "L" is designated for the visits with the medical providers, while the other side is where encounters for behavioral health occur. These distinct areas are connected by a window-lined hallway, which is just off the reception and patient waiting areas. The medical side contains eleven exam rooms, five of which contain large windows. In contrast, the exam rooms/offices in the old building contained small windows made of block glass at the tops of the walls. Overall there are more windows in the new building than the old, and the clinical area was often full of natural light. Although these brighter exam rooms may be more welcoming to patients and providers, I did write the following in my field journal following a day of fieldwork:

I noticed that the exam tables in these rooms face the windows, which overlook a street with row homes. These exam rooms are at the approximate height of the second floor windows of the row homes. This made me think about patient privacy during encounters, particularly during pelvic or other sensitive exams.

Each of the exam room windows had a movable shade, but the shade is partially see through.

At the center of the hallway in the medical side is a large desk. This is where the medical assistants sit. There are several computer terminals. Affixed to a corkboard at this desk was a typed quote that read: "Our job is not to judge. Our job is not to decide if someone deserves something. Our job is to lift the fallen, restore the broken, and to heal the hurting." Behind this sitting area is a half-wall beyond which is additional desk space with office chairs. The providers and scribes typically utilize this area to review the EHR and other clinical data (e.g., lab results). This space has a large window which overlooks the new parking lot. Adjacent to the desk where the medical assistants sit is a lab and an area for phlebotomy.

The behavioral health side is smaller in comparison to the medical side. The waiting area contains some chairs, a small desk with a computer and telephone, a watercooler, and a television. There are three meeting rooms, each with a large window overlooking a park. Each of these rooms contains a table and some chairs, and a white board. These are the rooms in which the social workers meet with patients and conduct individual and group therapy sessions. These are also the rooms in which the staff hold case management meetings. These meetings are a time for the medical and social providers, the nurses, and the caseworker to discuss patients who have complex needs. One informant described a patient with such needs as a:

Complex patient to me would be...the most complex I would think is one of our patients that is street homeless, not in a shelter, um, no phone, no, um, mailing address other than the Board of Social Services or a day shelter, um, repeatedly misses appointments, um, you know, often in the ER. They are...can be...or...and then also on top of that they may [have] substance abuse or mental health issues. Um, they're really complex.

There is also another room, without a door, with desk space and chairs and a large window overlooking a well maintained street.

In the days leading up to the move, I briefly spoke with Claire, a physician and the medical director, who said that she was “traumatized” by the move. On the actual first day that patients were seen in the new building, Claire mentioned that she felt “jittery” and “unnerved” by the move. During my semi-structured interview with her, I probed her more about these phrases. She said that she was feeling better about the move and that these initial feelings were likely the result of “a complete interruption of our routines.” Claire went on to say, “And you know again I sort of felt responsible for sort of taking care of-of everybody and-and, um, making sure that everyone – patients, staff – everyone was settled.” A few weeks later I noted that she was asking many of the patients she saw about the new building. I heard her remark to one patient that, “The building is for you.” The case manager, Lindsay, mentioned informally that she was getting used to the quiet of the new building, and that the old building had been loud.

Several months after the move to the new building one of the security officers told me that the building had been broken into and that some laptop computers were stolen. During the day I spent doing outreach, Lindsay told me that the building had been broken into a second time; a flat screen television was stolen from the common area. During another day, when I was speaking with one of the social workers, Kermit, I noticed a large crack in the window above his head. I said that it appeared to be in the shape of the sun; a large, circular crack with numerous “rays” jutting out from it. Kermit told me that someone was seen on surveillance video hitting it with a hammer.

Fieldwork

I use the term *fieldwork* to describe the time that I spent collecting data. Below I provide specific information related to three modes of data collection: my observations at the LHC (both in general and during patient-provider encounters), my experience observing informants conduct outreach work, and my individual, semi-structured interviews with informants.

LHC observations.

Fieldwork started in May 2015 and ended in February 2016. Excluding days when I went to the LHC to interview informants exclusively, a total of 58 hours and 40 minutes of fieldwork were completed. This includes two hours of outreach work outside of the LHC (described below). Given the small scale of this study, this is an appropriate amount of time and is consistent with descriptions of other types of studies using ethnomethods (Knoblauch, 2005).

Each day of fieldwork lasted between one and six hours. Prior to conducting fieldwork in which I observed patient-provider encounters I contacted the provider via email to arrange a day and time that would be convenient for her or him. For these encounters, I followed the provider as she or he saw patients. In the old building we remained in a single examination room/office; however, once the new building was completed and afforded more space, we moved among different examination rooms. Typically the provider introduced herself or himself to the patient and then I would introduce myself with some variation of, “My name is Tim and I am a nurse practitioner and a student researcher. I am spending several months in the office observing the interactions between patients and providers. I’d like to observe your visit today, but if

you would like me to leave at any time, please just let me know.” There were two instances where I went to the LHC to conduct fieldwork, but when I arrived I was unable to because the new building was not ready for patient visits. For example, I went to assist the staff with moving into the new building, but when I arrived at the site I was told that the move was postponed because the building had failed to meet a safety code. During the second instance, I was scheduled to observe the social workers, but because patients were not allowed in the new building yet, no observations were possible that day. Instead, on that same day Ray gave me a tour of the new building.

Encounters observed and unobserved. During the course of fieldwork I observed 79 encounters between patients and providers. Twenty-two of these encounters involved female patients and 54 involved male patients. I did not identify the gender of three patients in my field notes. I spent four days observing Ray (a physician assistant); five days with Rose (a physician); three days with Claire (a physician and the LHC’s medical director); two days with Carol (a psychiatric nurse practitioner); and five days with Buzz and Kermit (the social workers), either individually or together. Most of the encounters I observed included the medical providers. Table 2 presents the name of each informant and the number of encounters that I observed involving each of them.

Table 2

Number of Encounters Observed with Each Informant

Informant	Number of Encounters Observed
Carol	2
Claire	18
Ray	16
Rose	29
Buzz and Kermit	14

Over the course of my fieldwork, there were five encounters that I did not observe, mostly at the request of the patients. For example, one patient did not want any men involved in her care. Another patient did not want me to observe her breast examination. One patient wanted to discuss something privately with the physician. Once, Claire spontaneously saw a patient that was on another provider's schedule because she knew him well and because this was an unscheduled visit, I did not observe the encounter. There was a final encounter that I did not observe in which I made no notation of why in my field notes. In the instances where I was asked not to observe the encounters, I did not ask the providers what was discussed in the examination room, nor did the providers offer to disclose this information.

Reasons for encounters with health care providers. Patients at the LHC were seen by the health care providers for a variety of reasons, including to establish care as a new patient, to follow up from a visit to the emergency department for an acute concern, or to follow up for a chronic medical condition (e.g., hypertension or diabetes). The majority of the 79 encounters I observed were for an acute concern (e.g., dermatitis, muscle strain, or an upper respiratory infection) or to follow up for a chronic medical condition. In addition to these reasons, I observed encounters in which a new patient wanted to establish care at the LHC, when patients requested that forms be completed, and to review laboratory results. Other than one school physical, I did not observe any preventive or wellness visits. In addition to traditional primary care services offered at the LHC, specialty psychiatric care is provided by a nurse practitioner. The addition of this clinician was a strategy implemented by the organization to integrate primary medical and psychiatric care.

Medication-assisted treatment for opioid dependence. In addition to traditional reasons for visiting a primary care provider, approximately 125 patients are enrolled in a program to treat opioid dependence. I refer to this as the “Suboxone® program” throughout this dissertation; however one of the social workers commented when I used this term, suggesting an alternate phrase might be: “addressing the needs of persons with opioid dependence.” Both Claire and Rose are licensed to prescribe Suboxone® (i.e., medication-assisted treatment) to 100 patients each with opioid dependence. Thirteen of the 79 encounters I observed included patients enrolled in the LHC’s Suboxone® program; twelve of these visits were with Rose and one was with Claire. Additionally, I observed two encounters with Claire in which the reason for the visit was opioid dependence, but not necessarily involving patients taking Suboxone®. The Suboxone® program was started about two years ago. During my interview with Claire, she discussed how the idea for the program came about:

And you know what, I’d say that the medication-assisted treatment with Suboxone® also sort of evolved that way. I mean, from my second day that I worked here, my very, just still getting my feet wet, Kermit came in, sat down, and said, ‘What do you think about Suboxone®?’ So we sort of got the-the ball rolling thinking about it for a couple years and how it would, how it would work in this population before we...

Although proportionally the number of patients participating in this program is low compared to the overall number of patients seeking care at the LHC, the program is time intensive. One of the social workers estimated that about one half of his time involves interacting with patients enrolled in the program. This same provider noted that prior to embarking on this program he did not think that his involvement in the program

would be so intensive. I noted the process patients go through in order to start in the Suboxone® program in my field notes:

I asked [an informant] something like, ‘If I wanted to start taking Suboxone®, what would the process be like?’ Essentially, the patient is initially seen by one of the social workers for a visit that is approximately 45 minutes long. This is an opportunity for the SWs to determine whether the patient is a good candidate for Suboxone®, or whether she or he would benefit more from other treatments – e.g., methadone or inpatient detox. (Buzz provided me with a copy of an intake form that the SWs use at that visit. It does ask about hepatitis C and HIV screening). The next step is that the patient meets with a provider (if the SW deems the patient appropriate), and the patient is started on the medication [Suboxone®]. Kermit agreed when I asked that it was essentially the SWs who drive this program. He did say that he wished that the [prescribing] providers had more of an active role. Kermit mentioned that they usually do standard labs on patients new to taking Suboxone® at the second visit.

Even though the social workers’ recommendations for the appropriateness of the patients is considered heavily in the final decision to either start a patient on Suboxone® or not, the prescribing health care provider makes the final decision. An example of this, and some additional details about the program, were described in a field note as:

The second patient that we saw together was a man that wanted to start Suboxone®. Before meeting with him, Claire looked through his chart and noted that it seemed like what the patient really wanted was to use Suboxone® to detox from heroin – This was confirmed during the visit when he talked about wanting Suboxone® for a short period of time. I noticed that the man was sweating during the visit. Claire asked him when he last used heroin and he told her about three hours prior to the visit. He was alert and coherent during the visit, but I wondered about the ethics of doing the visit with someone who was essentially high. She listened intently to him, but told him that she would like him to be on Suboxone® for a while, and that the medication was not indicated for detox per se – That her license to prescribe this medication could be in jeopardy if regulating bodies like the state and DEA [Drug Enforcement Administration] knew that she was doing this. She went on to explain that he should take the medication at least 24 hours after he last used heroin, and that if he could prolong that interval, doing so would be more beneficial – She told him that the ‘sicker’ he was when he took the first dose, the better – Taking it too soon after last using heroin would essentially put him in withdrawal. She explained the procedure for obtaining Suboxone® – The nurse would need to get authorization from his insurance provider and that might take a day or so. She said that she wanted him to follow up with her in three days.

He was willing to do this and by the end of the visit seemed to understand that he would need to take the medication for a longer time period than he initially wanted to. Claire later mentioned that both Kermit and Carol did not think that this patient would be a good candidate for Suboxone®. However, she decided that he should try it, going on to say that in her experience the patients she didn't think would do well, actually do, and the ones that she thinks would do well, don't. After the visit she went to speak to Kermit (I was not present for this conversation). Kermit then went in to meet with the patient (I observed this encounter) – He reiterated much of what Claire said and asked the patient if he had any questions. The patient then met briefly with the nurse and was on his way.

Of note, during the course of my fieldwork Claire sat for and passed the addiction medicine boards.

Discussion of any aspect of sexuality. Given my initial research question at the outset of the study, I was particularly interested in observing any mention of aspects of sexuality during patient-provider encounters. Although no formal sexual histories were observed there were instances in which concerns or topics that may or may not be related to sexuality were observed. The types of visits in which such observations were made can be broadly classified into: ordering or following up on screening labs (e.g., hepatitis C or HIV), the evaluation of symptoms, preventive or wellness care visits, following up on chronic conditions, or visits in which patients initiated a discussion of an aspect of their sexuality. For example, during the two encounters I observed with Carol she asked both patients if they had ever been sexually abused. During another encounter a patient requested screening, “For all diseases” because he recently learned of some of his girlfriend’s behaviors. In two separate encounters, one patient asked the provider about erectile dysfunction while the other patient requested a prescription for Viagra®. Two examples of encounters for the evaluation of symptoms involved women who presented with urinary frequency and urgency and abdominal pain, respectively. In none of these

examples were “typical” sexual histories, such as those recommended in current CDC (2016) guidelines, collected.

Outreach observation.

Many of the staff of the LHC do outreach work. This includes seeing patients off-site at other organizations or canvassing the city for homeless persons to make them aware of the LHC’s services. After hearing some of the informants discuss this type of work I decided to join them one morning. I wrote about the experience in my field notes:

This morning I went along with Lindsay, a medical student, and a yearlong volunteer working at the organization to do outreach work in the community. This is essentially a time for the staff to let homeless people in the community know about the organization, and solicit them for appointments. Since I needed to be in [name of the city where the LHC is located] by 6:00 AM, I decided to drive and am glad that I did because it was raining. Lindsay told us that the CEO is considering stopping outreach because it is not bringing in a large number of new patients. Lindsay drove a minivan around the city looking for homeless people – we drove by the waterfront, climbed up under overpasses, walked through abandoned buildings, and visited shelters. We did get to briefly interact with several people under the overpasses; there were about 6 people under one. They all appeared young, maybe around my age. It was interesting to see how organized and tidy this area was; individuals had shoes lined up (I assume to dry) and their other supplies laid out. The medical student passed out bottles of water, breakfast/granola bars, and clean socks (of note, in the back of the van, there were bags of condoms). We walked through two abandoned buildings. Although they were essentially crumbling, there were dry areas to be found. And I couldn’t help thinking that they were beautiful spaces; I wanted to take pictures of the abandoned spaces filled with bricks and other building materials and refuse. I was particularly taken by the gray light poking through the holes in ceilings. We spoke to one man who was sleeping on a sofa in one of these buildings (we later saw him again at the shelter). He was very pleasant and appreciative of the provisions from the medical student. He told us about a rash and Lindsay was able to get him an appointment for 1 PM [that same day]. At the shelter, we met a woman who told us she had most of her belongings stolen the night before, including her driver’s license and medications. She mentioned at one point that she felt like hurting herself. Lindsay offered her an appointment right away, and the woman asked if we could drive her to and from the shelter – this was almost 8:00 AM and the woman wanted to be back for breakfast at 9:30 AM because she was so hungry. We all got back in the van and drove the woman to the office.

Informant interviews.

Twelve informants were interviewed as part of my research. Almost eight additional hours were spent interviewing individual informants. Table 3 presents the names of the informants as well as their job titles.

Table 3

Informants' Job Titles

Informant	Job Title
Baschaliah	Medical Assistant
Buzz	Social Worker
Carol	Psychiatric Nurse Practitioner
Claire	Physician & Medical Director
Danielle	Peer Advocate
Kermit	Social Worker
Lindsay	Case Manager
Ray	Physician Assistant
Rose	Physician
Sherrie	Clinical Care RN
Sue	Ambulatory Care Nurse Manager
Toni	Certified Application Counselor

Each interview lasted between 25 and 54 minutes and each was digitally audio-recorded. Each informant was interviewed once. Interviews were conducted at the clinical site in a private location (e.g., an empty office or examination room). By the time I completed my fieldwork three informants were no longer employed at the LHC (i.e., Carol, Lindsay, and Sherrie) and other staff members had been hired (e.g., two clinical care registered nurses).

Main Findings

In an effort to understand why typical/traditional sexual histories were not routinely collected and gain a greater understanding of what *was* happening during encounters at the LHC I reread all of the memos I wrote from my field notes. These were

categorized as pertaining to: specific patient-health care provider encounters, the informants and other LHC staff, the LHC as an organization, the researcher, the physical setting of the LHC (i.e., the building), the patients, and the surrounding community. I then reread for gestalt all of the interviews with the informants most likely to collect sexual history data (i.e., the clinical care registered nurse, the medical assistant, the nurse practitioner, the physicians, and the physician assistant). These interview transcripts were then scrutinized; looking specifically for content and factors that contributed to the absence of the collection of sexual history data as well as content reflecting my revised study question. Similar to the classification of the memos from my field notes, the content from the transcribed interviews were categorized as: organizational considerations, patient characteristics, provider characteristics, visit characteristics, and the work environment. From these, the main findings were derived. Each of these main findings is discussed below, but are not done so in terms of impact on sexual history data collection (i.e., *persons served by the LHC* are presented first, but this does not mean that it had more or less of an impact than *communication between patients and providers*, for example). Rather they are meant to be considered as occurring simultaneously; and there is some overlap among categories.

Persons served by the LHC.

Through my immersion in, and previous knowledge of the LHC, I had a broad understanding of the characteristics of patients seeking care at the LHC. However, I wanted to learn more about how informants described patients. During semi-structured interviews with informants I asked them to tell me about the patients that visit the practice. Some individual informants responded by describing patients in terms of their

common health conditions and/or concerns, such as addiction, mental health, hepatitis C, hypertension, strokes, heart attacks, and cancer. Additionally, one informant noted that many patients require referrals to pain management specialists. Yet across interviews informants described patients as underserved, homeless, traumatized, poor, underserved, uninsured, transient, disenfranchised, poverty-stricken, complex, having psychiatric and substance abuse issues, lacking support systems, having low expectations of the health care system, having the least amount of access, and high utilizers of emergency services. Some informants made distinctions between the patients described above and “our regular people” (i.e., those that have housing in the community and are employed). The following excerpt highlights the variety of patients seen at the LHC:

Interviewer: In general terms, can you talk a little bit about the types of patients that come here for care?

Informant: Um, it’s an interesting mix because we, um, we see community members, um, you know, who-who have...who...you know, have employment, have families, are-are very, um, I guess I could say stable. Um, down to people who are, um, couch surfing, which is technically homeless. Um, but they’re a little more stable to people in the shelters, um, and then to people who are street homeless. I mean, I...I’m proud that we serve the street homeless population. Because, um, that’s the population that when they go to a lot of doctors’ offices and specialty care, they’re treated really poorly and I think when they come in here, they’re treated with respect, um, just like anybody deserves. Um, you know, they’re given the same exact quality of care that somebody from one of the fluffy suburbs around there would be given.

Informants also talked about how they (the health care provider) think patients perceive the LHC, for example, in terms of what types of services are provided and by whom and how that may influence patients’ expectations of how they can be helped. Following an observation of an encounter involving Carol, I noted that the patient, “Mentioned a couple of times that when he gets an HMO he’ll be able to ‘get a real

doctor.’ After saying this, the NP [Carol] told him that the doctors in the office were all board certified.” I explored the idea of patient perception of the LHC further during my interview with Toni, the certified application counselor. Toni offered the following:

So unfortunately, yeah. I think there are people out there that look at us as just for the homeless. Um, we also get a lot of just, for, um, opioid treatment. You know what I mean? Um, I think people in the neighborhood, some are...if they don’t know of us or like what we do they’re afraid of who we...who we attract here, quote, unquote. You know what I mean? Um, but...so yeah, I do think if you have never been here you...and you know you’ve only heard some people tell you about like what we do here, you may not know and you may assume that it’s for a certain type of people. But I think once you get here, you know, and you meet the providers and they treat you with respect, you know, you get a sense that oh, this is for everybody. You know, regardless of if I’m coming in off the street or if I’m coming in here Monday night after work or you know, it...it’s for everyone.

Although I did not interview patients about their perception of the LHC, nor did I ask all of the informants about their thoughts on this issue, what is clear from my observations and interviews is that some patients may perceive the LHC as not being able to meet their needs because they are not homeless or dependent on opioids. It is only with exposure to the organization, and the services provided therein, that patients gain an appreciation for how their needs can be met. With exposure to the LHC, either directly as a patient or through word-of-mouth from friends or family who receive care here, patients come to understand that not only their medical concerns will be addressed, but also many of their social needs.

The immediate, basic needs of some of the patients at the LHC supersede what providers’ hope to address during encounters. This prioritization is influenced by many factors, including patients’ ability to communicate, and providers’ willingness to adapt their practice to meet patients’ specific needs and concerns. In addition, a factor observed

to play an important role in addressing needs and concerns is communication between patients and providers.

Communication between patients and health care providers.

No matter the reason for patients' visits to the LHC, effective communication between patients and providers is essential for collecting information from patients, sharing information with each other, making a diagnosis, and creating a treatment plan. During my fieldwork I noted many factors that likely influence how patients and providers communicate with each other in the course of a single encounter, including patient-provider positioning in the examination room (due to the physical layout of the space), making eye contact, using a laptop, taking handwritten notes, the presence of additional people (e.g., patients' family members or friends, the scribe, and the researcher), and the use of silence. Despite differences in how individual providers were influenced by (and did or did not use) these factors, in individual interviews with informants, factors influencing communication were mentioned that may contribute to the absence of sexual history taking. One provider noted during an interview that there are:

Barriers to communication and you may not, you know, realize it until the patient has already left. But you may, you know, just have handled something in a way that could've been done better. Sometimes our patients don't always have the highest level of medical, um, savviness.

She went on to explain this further and also mentioned that patients are sometimes perceived as "mean" which may impact communication:

So it's you know, sometimes we expect them to know things that we get upset with them for not knowing; things that we expect them to know but we don't explain [to] them really. Um, so sometimes, that happens and that can be very frustrating. Uh, we do have some issues of course, um, you know, there are some

people who are, you know, looking for something from you like pain medication and things like that; that happens, that's not as frustrating. I mean it does happen a lot but it's, um, can sometimes, sometimes, can, people can sometimes be mean about that.

Another provider, when talking about respecting people as her philosophy of care, mentioned that some patients "are not very nice." Although I did not observe any instances in which I perceived patients as being mean to providers or vice versa, these comments highlight the need for appropriate professional interpersonal relationships to be formed to facilitate the exchange of information between patients and providers, including the collection of sexual history data. As these informants note, effective and therapeutic communication can be hampered if providers do not communicate with patients in a way that is clear and understandable, if there is a mismatch in demeanor between patients and providers, or if patients' are perceived as capitalizing on providers' ability to prescribe medications (e.g., analgesics) as a means of meeting some demand.

Informants also noted that it is often difficult to reach patients via telephone or mail and that language differences can impede communication; the latter is overcome through the use of an outside interpreter service and bilingual staff who are available to translate. The medical assistant offered that patients sometimes are hesitant to tell her the reason for their visits, particularly if it is related to some aspect of their sexuality such as being concerned about having a STI. She noted that she overcomes their reluctance to offer their reason for the visit by assuring them that, "We are here to help you...Not to judge you. That's, you know, we're here to just make things better for you, but I need to know what needs to be made better." I asked this same informant if she thought that patients were more willing to disclose information to her rather than the health care

providers. She offered that is likely a common occurrence, and may be a function of patients' viewing her as less intimidating than health care providers; although she offered that she does not believe any of the health care providers are intimidating. These examples illustrate that language, patients' reluctance to disclose information, and patients' perceptions of providers may impact the exchange of information between patients and providers, including sexual health data

Patients' immediate needs in the context of organizational mandates.

More than once, the health care providers expressed how much they like working with the patients seen at the LHC, and noted that patients' immediate needs often supersede what the providers would like to address in the course of a patient visit. One provider offered:

Sometimes patients have other needs that come first like mental health, or housing, or food, or whatever they need, or addiction, um, whatever they need at the moment. So we try to balance primary care with, and, medical care with other forms of care.

Another health care provider offered a more specific example related to cervical cancer screening and the challenge of performing Pap smears in the context of the LHC:

Health care provider: So I don't think it's quite as dire as it was but it's still pretty dire. And we still have a hard time getting women to get their Pap smears.

Interviewer: Yeah. Why do you think that is?

Health care provider: I think some of it is trauma, like some of it is traumatic.

Interviewer: Uh-huh.

Health care provider: Um a-a lot of visits end up you know you sort of, I have GYN visits on my schedule and then when someone comes in they are so overwhelmed by some other problem that they say, 'Can we please skip this and do something else?' Of course I am going to say yes.

Interviewer: Sure.

Health care provider: Like I'm not going to get you up in the stirrups if you're, you know, upset about something else. It's not-not good use of anyone's time, so.

Most encounters that I observed were for acute and chronic concerns that did not necessitate the collection of sexual history data. This data, as mentioned previously, may more commonly be collected in the course of wellness visits or during visits where the concern is related to some aspect of patients' sexuality (e.g., birth control, STI screening, or urethral or vaginal discharge). Some providers acknowledged that health maintenance and preventive care are always considerations, yet aren't always able to be addressed given the context of a particular visit. One provider offered:

And HM...health maintenance is always a bullet point. Sometimes I get to it and sometimes I don't. It's always at the bottom so it depends on how quickly we move but I try to be, you know, put it on the note with like high hopes we're going to get there [Laughing] and sometimes we do and sometimes we don't.

In addition to patients' needs, the LHC is also mandated to report certain clinical data to the federal government. These quality of care measures, although important, may influence what types of care are delivered within the LHC.

The LHC is a grantee of the Health Resources and Services Administration (HRSA)'s Health Center Program. Each year participating health centers must report specific clinical data. These data include: the age and race/ethnicity of patients, the characteristics of patients (e.g., the percent who are uninsured and who are enrolled in Medicaid and Medicare), the types of services provided (e.g., dental and mental health), clinical data (i.e., the percent of patients with certain medical conditions and quality of care measures), and data on cost (U.S. Department of Health and Human Services [HHS], 2016d). The quality of care measures are subdivided into three categories: perinatal

health, preventive health screening and services, and chronic disease management. Table 4 lists the types of preventive health screenings and services and chronic diseases that grantees are required to report.

Table 4

HRSA Health Center Program Quality of Care Measures (2014)

Preventive Health Screening & Services	Chronic Disease Management
Cervical cancer screening	Asthma treatment (Appropriate treatment plan)
Adolescent weight screening and follow up	Cholesterol treatment (Lipid therapy for coronary artery disease patients)
Adult weight screening and follow up	Heart Attack/Stroke treatment (Aspirin therapy for ischemic vascular disease patients)
Adults screened for tobacco use and receiving cessation intervention	Blood pressure control (Hypertensive patients with blood pressure < 140/90)
Colorectal cancer screening	Diabetes control (Diabetic patients with HbA1c <= 9%)
Childhood immunization	HIV linkage to care
Depression screening	

In addition, the LHC is also a grantee of the National Health Care for the Homeless Program and as such reports additional data, which is aggregated with data from other grantees. These data include selected diagnoses and services rendered (U.S. Department of Health and Human Services [HHS], 2016b). For example there are data on several STIs, dehydration, exposure to cold and heat, and substance related disorders. Additionally (this is not an exhaustive list of all reportable services), data are available related to dental services as well as other preventive services, including immunizations, hepatitis screening, mammography, and contraception (HHS, 2016b).

During my interview with Claire, she noted that having to report these data was new to her and that it was not necessarily being collected in any systematic way. She stated:

And when I saw our, like the numbers, so we were just starting to do this reporting because we were still a relatively new FQHC. And I remember seeing the first batch of numbers and they were all done by sort of chart mining. You know, like, even though we had [an] electronic record we did not know how to pull the data out so it was chart reviews. And, um, and they had someone non-clinical pulling this information out of the chart. Like it was like, whoa, wait a minute, like this is insane. Like we're not, we're probably not capturing all of the data just into the record in the first place and then how do we know that it is being extracted correctly? So the first time that we had to do all this reporting for UDS [Uniform Data System] I decided I was going to do it all myself by hand [laughter].

She recalled that undertaking this process was “emotionally devastating” because it was not only time consuming, but she realized, “We’re just doing a crappy job at this.” To improve and make this process less laborious the LHC recently purchased a software package to aid doing quality improvement work around population management.

Considering the HRSA reportable preventive health screening and services, none are specific to patients’ sexual health or sexuality; more specific data related to homeless persons and sexuality are reported as part of the National Health Care for the Homeless Program. Although I did not directly collect data from the EHR, I wanted to know if there was a section of the EHR devoted to the sexual history. Prior to my interview with Baschaliah she showed me a blank chart in the EHR. Under the “social status” section was a tab labeled “sexual activity.” I asked her that if when she clicked yes on this tab would it populate additional questions related to sexual activity and she said it would not. I did not have access to the EHR to look for additional templates, nor did I ask providers if and how they documented sexual histories, and more generally health histories, in the

EHR. EHRs are a tool for collecting data, many of which are used for reporting purposes and quality improvement. In the case of sexual histories, if the EHR contains no prompts for a comprehensive history, then this additional information cannot be documented; however there are likely others places in the EHR where providers are able to freely input a more detailed sexual history. At the LHC, the psychiatric nurse practitioner was also in a position to potentially collect some sort of sexual history data as a result of her interactions with LHC patients. Although I only observed two encounters between the nurse practitioner and patients, she did ask about a history of sexual abuse in both instances. Initially the nurse practitioner did not want me to observe her encounters with patients because she felt they would be less forthcoming with her if a stranger was present in the room. As my fieldwork progressed she sought me out to tell me that she was finding that many of the patients she was seeing reported a history of sexual abuse. During our interview she offered an estimation of the number of patients who experienced sexual abuse:

Well these patients are very, um, I'd say ninety percent of the patients that I see here have been sexually molested as kids. They're very sick patients, uh, from a psychiatric point of view. Uh, they've-they've used drugs to numb what's happened to them. Uh, it's a challenge but it's the patients that I've always liked. So I've always worked with this, uh, population. In order to work here you would have to have a lot of experience, it couldn't be a new provider at all, uh, the patients are just too sick.

In many primary care practices, preventive health measures are likely to be discussed in the course of a wellness visit (or if time permits fitting them in to visits that focus on acute or chronic concerns), and this might also include collection of sexual health data. Given that I observed only one wellness visit in the course of my fieldwork (i.e., a school physical), there were no other opportunities to explore how wellness care (and if sexual

histories are collected more frequently during these types of encounters) is delivered in the LHC.

One reason for few opportunities to observe wellness (well woman visits in particular) visits is that the LHC has a quarterly Women's Health Day. On these days no men are permitted in the LHC. Advertised as a "girls only event" it is an opportunity for women to have cervical cancer and other screenings. This program was implemented to increase the number of cervical cancer screenings (an HRSA quality of care measure for FQHCs). On my first day of fieldwork I saw a handmade poster in the waiting room that provided information on the number of Pap smears performed in the LHC over the past three years: only three in 2013; approximately 75 in 2014; and approximately 15 as of May 2015. Sue noted that this program was instituted in response to low rates of cervical cancer screening and providers' feelings that the physical setting of the old building was a barrier to this type of screening. Sue describes the evolution of the program as:

The idea with the 'Paps and Purses' program was to create the environment that is more conducive to women wanting to come in and get a Pap. Because especially...and not too much in this building, but in the old building, um, it was not conducive to women wanting to come in and get a Pap smear. You know, the...this crowded hallway and-and you know, very little privacy and um, just wasn't a good atmosphere for that. So to...to have the...we call it the Women's Health Day, the Paps and Purses, time set aside that's just for women to come in and get Paps on that day, um, you know, just to make it a little more desirable for them.

On my first day of fieldwork I asked Claire if I could observe encounters on the upcoming Women's Health Day, but she said I would not be able to given I am a man. The most recent Women's Health Day was held in the new building. According to Sue, during this event:

There were eight visits listed as GYN, however five PAPs were done. One of those visits was actually a new Suboxone®, one was with a woman who had a hysterectomy, & one was a woman who comes to every WHD [Women's Health Day] but has normal PAP results so is only covered every three years by insurance to have a PAP done. WHD is quarterly... We've been doing it for two years & I have not analyzed the data but off the top of my head would say we normally do between 6-10, depending on the day.

It is also important to note that the physician assistant does not routinely do cervical cancer screenings; he refers women to one of the female physicians.

Many encounters that I observed were for chronic diseases (several of which involved diseases that need to be reported to HRSA), yet no sexual histories were collected in the course of these types of visits. There were instances (discussed above) in which patients initiated conversations about problems in which these uncontrolled diseases were likely contributing to adverse effects on their sexual health. Even though these concerns were not explored in depth by the health care provider involved in the encounter, there was an acknowledgment that such concerns are important to patients. After an encounter involving a patient following up on lab work and arthritis, I wrote the following field note:

The patient asked for a prescription for Viagra®. [The health care provider] asked few questions about ED [erectile dysfunction], but told the patient that it might be due to his elevated sugar. The patient also has hyperlipidemia. I thought that this was a missed opportunity to talk about sexual health. No SH [sexual history] was taken. The patient did mention that he is currently living on the street and [the provider] referred him to the social workers and case managers for assistance with obtaining food and shelter. After the visit [the provider] said, 'you can have so many problems, but that one, across the board, is so important to people' [referring to ED].

Although many informants discussed that patients' immediate needs and concerns are prioritized in the course of encounters (discussed above), the example above illustrates that in the course of a "real-life" example, health care providers and patients

may direct the visit to an alternate priority or need. I observed and listened to health care providers talk about prioritizing care based on immediate needs or to meet quality of care measures, and as a result, traditionally defined preventive health care was limited and in terms of sexual health, only HIV screening included.

Health maintenance and preventive health care may have narrow foci for providers in the LHC. One provider noted that he does not do much preventive health care, but went on to say that he discusses exercise and limiting certain types of foods with patients; advises them to take aspirin daily; recommends that female patients see a GYN provider; and refers patients for colonoscopies and diabetic eye and foot examinations. It is clear that he is appropriately performing health maintenance with patients, but the scope is limited. HIV screening was sometimes offered by providers in the context of ordering other labs, but was not preceded by any sexual history taking.

The schedule.

Finally, scheduling patients in the LHC is another important aspect of providing care within organizational mandates. During interviews, informants expressed that many visits warrant more time than the typical 15 minutes usually scheduled for a follow up visit; for example, that 20-30 minute appointments may be more helpful in terms of facilitating health maintenance concerns. In addition, how appointments are scheduled has been an area in which there has been ongoing change at the LHC. Currently the LHC has an open schedule policy; patients can call and get a same day appointment.

Previously providers' schedules were pre-booked, but Claire noted that when she first started working at the LHC, many patients were rescheduled if they were late or missed an appointment; they may not be able to get another appointment for several weeks. She

mentioned that if her schedule was full (i.e., approximately twenty patients pre-booked for an eight hour day), only three to ten would show up at their scheduled time. Claire offered:

I'd be sitting in my office in that small little building where we were and I'd be reading my Kindle because I had nothing to do. Reading my Kindle and hearing people get turned away at the front desk saying that the schedule was full, um, you know they needed to you know make an appointment. And they'd get an appointment for like three weeks from now. Um, or people show up after fifteen minutes because they missed their appointment and even though there'd be nobody else in the building they'd still get to say 'oh, you missed your appointment, you need to reschedule. Here's your next, the next available is three weeks from now.' And I would be sitting there like what is the, what world does this work for? Like we're not meeting any productivity and it's not helping our patients whose lives don't work this way. And I am sitting back here doing nothing. Like could you just like let me see a few patients?

The LHC then moved to a pre-booked schedule that did allow for some walk-in appointments, but patients would need to wait for an available walk-in slot. This caused crowding in the waiting room and often long waits for patients. Claire noted that the no-show rate continued to hover around 40% - 50%, so the LHC moved to an open schedule. As Claire mentioned, this allowed the LHC to try to increase productivity while considering the context of patients' lives outside the LHC.

Summary

In this chapter I have woven aspects of data collection and analysis with the major findings of this focused ethnography. My original goal was to gain an in-depth understanding of how sexual health data were collected, evaluated, and used in the course of patient-health care provider encounters. What I found instead was that traditional, biomedically based approaches to addressing sexual health were virtually absent from this practice and this allowed me the opportunity to examine a broader question and use

an ethnographic approach to understand what *was* being collected during health histories and how providers were evaluating and using that data.

Although the LHC is a relatively small organization it provides primary care services similar to other practices. What is unique to the LHC is that it serves a large number of persons who are homeless or housing insecure with common acute and chronic medical concerns, as well as psychiatric concerns and opioid dependence. Often patients' social needs supersede their medical and psychiatric concerns. I am reluctant to label the main findings as barriers to the collection of sexual history data. Instead the findings highlight factors that may or may not explain the absence of formal sexual history taking and provide a detailed description of how the LHC serves a population of highly vulnerable, high-risk individuals by *collaborating to communicate, meeting people where they are, reconciling and addressing scheduling challenges, addressing patients' immediate needs, and re-framing preventive care in the context of organizational mandates*. This focused ethnography is an initial attempt to understand these factors.

In chapter five I present the conclusions and implications of this study. I will also discuss the unique contribution of this study to the existing literature on sexual history taking, as well as discuss its strengths and limitations and how the findings will inform future research and practice.

Chapter Five: Discussion, Implications and Conclusions

Introduction

In chapters one and two I presented the rationale and background for undertaking the current study. Chapter three detailed the methods used to conduct the study, and I presented the findings in the previous chapter. In this final chapter I briefly summarize the study. I then discuss the study findings in relation to current literature, strengths, and boundaries of this particular inquiry and implications for future education, practice, and research.

Summary of the Study

Much of the literature on sexual history taking has focused on the content and documentation of sexual histories. Barriers to sexual history taking have also been an area of inquiry related to this clinical practice behavior. The data collection methods for these studies have been relatively homogenous and primarily include retrospective chart reviews and self-administered questionnaires. Given the low rates of sexual history taking (determined through retrospective chart audits) some interventions have been developed to increase the documentation of sexual histories as well as to improve health care providers' comfort with, and confidence in, sexual history taking; however, studies of these interventions have been limited by small sample sizes using pre- and post-test designs. Given the narrow focus of the existing literature, and considering the limitations of the data collection methods used in these studies, I undertook a qualitative study to explore sexual history taking in daily clinical practice. Specifically, my aim was to answer the following question: How do health care providers collect, evaluate, and use sexual history data during health care encounters with patients? In an effort to answer this

question I conducted a focused ethnography at a single primary care practice in a city in the northeastern part of the United States.

I conducted fieldwork from May 2015 until January 2016. Data were collected through situational conversations, passive observations of patient-health care provider encounters, semi-structured interviews, and field notes. Over the course of my fieldwork I observed 79 encounters between patients and health care providers (i.e., physicians, a physician assistant, a psychiatric nurse practitioner, and social workers). During none of these encounters was a sexual history (using CDC guidelines as a template) taken.

Although many of the encounters were for acute or chronic concerns that did not necessarily warrant the collection of sexual history data, I observed instances where collecting sexual histories may have been appropriate. Given these data I could easily answer my initial research question: Sexual histories were not collected during health care encounters with patients (therefore, they could not be evaluated or used in practice). However, as fieldwork progressed, I wanted to understand why this data was not being collected and a new question emerged: What historical data *are* being collected, evaluated, and used in context of the LHC? The main findings from the study highlight that *patients' characteristics, communication between patients and health care providers, and addressing patients' immediate needs within the context of organizational mandates* influence day-to-day clinical encounters as well as practices associated with sexual health and sexual history taking in the LHC.

Discussion

Persons served by the LHC.

The absence of sexual history taking at the LHC is inconsistent with studies involving adolescents and adults in other primary care practices, where the documentation of sexual histories was found to be higher (although still low, particularly among adults). For example, Loeb et al. (2011) reported that only 25% of 360 retrospectively reviewed charts from patients seen by internal medicine residents included at least one component of a sexual history. Higher rates of sexual health discussions have been found in studies using audio recordings of patient-health care provider encounters. Ports et al. (2014) reported that some discussion of sexual health occurred in approximately 50% of 483 periodic health exams involving adults 50 – 80 years old. Higher rates of sexual history documentation have been found in pediatric primary care settings. Banas et al. (2010) reported that 76% of 224 health records from females 13 – 21 years old contained information related to sexual health. In another study of 253 patients who were 12 – 18 years old, 65% of their audio-recorded visits contained some talk about sexuality. The finding in my study, that no sexual history taking occurred, is consistent with only one other study in which there was no documentation of sexual histories in the health records of 25 adolescents with a life-limiting illness (Sargant et al., 2013).

Khan et al. (2008) found that health care providers feel uncomfortable dealing with persons that are injection drug users and sex workers. Although I did not collect demographic data from the patients whose encounters I observed, the LHC serves a vulnerable population of persons many who are seeking treatment for, and assistance

with, multiple chronic health and psychosocial concerns. Despite the challenges of caring for this population, health care providers at the LHC were not uncomfortable interacting with homeless persons, nor were providers uncomfortable caring for patients with additional vulnerabilities, including opioid dependence. Although the findings from my study are not consistent with providers being uncomfortable with a particular patient population (Kahn et al., 2008), it may be that in a setting such as the LHC, it is the individual person and/or the needs of the setting in general that account for what I found as an alternate, non-sexual health focus during “typical” primary care encounters at the LHC. My study differs from, and goes beyond those described above (Banas et al., 2010; Loeb et al., 2011; Ports et al., 2014) by employing a qualitative approach, reporting sexual history taking among a sample of primary care patients who are mostly homeless or housing insecure and being treated for opioid dependence. These findings add to the literature on sexual history taking, particularly regarding the practice of providing care for vulnerable populations.

Finally, in terms of persons served by the LHC, the theory of culture care diversity and universality (Leininger, 1997; McFarland & Wehbe-Alamah, 2015; Wehbe-Alamah & McFarland, 2015a; Wehbe-Alamah & McFarland, 2015b) proved to be a useful guide for considering the multiple factors affecting the practice, and lack of observed sexual history taking at the LHC. Although I had hoped to discover and document the context in which sexual history taking occurred, my fieldwork led me in a different direction to broaden my question and describe factors that may contribute to what was being collected during primary care encounters and possibly why sexual health data were not collected by health care providers in the LHC. I could have explored sexual

history taking through any one of the factors included in theory (e.g., a focus on the environmental context; Wehbe-Alamah & McFarland, 2015b); however I chose to use the theory as a guide for considering the multiple factors associated with the delivery of health care services in a particular practice. In doing so I was able to look beyond the confines of the examination room to the wider influences on health care providers' practices within the LHC, including organizational mandates, the prioritization of patients' basic needs, and how collaboration and communication impacted caregiving at the LHC.

Communication between patients and health care providers.

In the broader literature on sexual history taking factors influencing communication between patients and health care provider have been identified. *Limited communication skills* was reported to be a barrier to sexual history taking by 29% of 100 nurse practitioners (Maes & Louis, 2011). Additionally certain attributes of patients, including being a man who has sex with other men (Barber et al., 2011), a sex worker (Do et al., 2015; Khan et al., 2008), having a STI (Khan et al., 2008), being and intravenous drug user (Khan et al., 2008), or being an older person (Gott et al., 2004) have all been identified as barriers to sexual history taking. Health care providers have also reported that not knowing how to take a sexual history (Haley et al., 1999) and fearing that discussing sexuality will embarrass patients (Barber et al., 2010) are also barriers.

Although factors identified in previous studies (Do et al., 2015; Gott et al., 2004; Khan et al., 2008) may have impacted communication in the LHC, a number of additional, and in some cases quite unique factors not previously reported in the literature

were identified. These factors include not being able to reach patients by mail or telephone; patients' whose primary language was one other than English; health care providers' perception that patients were unkind or seeking controlled substances; patients not wanting to offer the reason for their visit to frontline health care providers; and health care providers' communicating information ineffectively. To my knowledge only two of these factors have been reported previously: language barriers and ineffective communication. Gott et al. (2004) reported that a barrier to discussing sex was patients and health care providers not sharing a common language. Specially, concerns that certain medical phrases would not be translated correctly; the presence of an interpreter could jeopardize patient's confidentiality and/or depersonalize the encounter; and that the interpreter may be embarrassed were all reported. Maes and Louis (2011) reported that almost a third ($N = 100$) of nurse practitioners reported that *limited communication skills* were a barrier to sexual history taking. Unfortunately these authors did not provide an operational definition of this barrier. Given the unique patient population served by the LHC, the additional factors (i.e., difficulty with reaching patients via mail and telephone and health care providers' perceptions that patients are unkind or seeking controlled medications) are important to the scholarly conversation regarding the impact of communication on sexual history taking.

Symbolic interactionism (Blumer, 1969) also informed my study. When I began fieldwork I expected to observe sexual history taking, discuss the meaning of sexual history taking with informants, and examine sexual history taking via a framework consistent with symbolic interactionism by documenting the content and describing the meaning of interactions between patients and health care providers. Although the specific

study question changed, the symbolic interactionism perspective remained important to inform all phases of the study, including examination of one of the main findings, that communication between patients and health care providers plays a key role in how primary care and sexual health needs are incorporated within a setting such as the LHC. Moreover, the communication factors highlighted by my study have meaning for both patients and health care providers and in turn, these meanings likely influence the actions taken towards the factors. A clinical example of how symbolic interactionism is relevant to the meaning of a specific health care encounter and where sexual health *could* have been discussed (in relation to the patient's diabetes) but instead, the interaction is focused on how the health care provider communicates and is open to a revision of the visit goals, follows:

The health care provider begins the encounter with a likely intention of discussing the patients' uncontrolled diabetes; however, early in the visit the patient mentions that she has been sleeping on the street for the past three days and has not had a meal in the last 24 hours. For the health care provider in this instance, the ability to communicate with the patient in a truly patient-centered fashion, and the meaning of what transpires between the two parties, leads to a change in the focus of the visit; rather than solely addressing a provider-determined medical concern, this interaction leads to problem solving and a focus on working with the patient to meet her basic human needs.

Therefore, the health care provider abandons (or puts off for a time) initial goals for the visit and takes action to call a shelter and arrange a more secure setting for housing and food.

This vignette provides an example of what health care providers in my study noted was a common practice at the LHC: having to modify their agendas for encounters in order to meet the crucial needs of patients. These needs are addressed within the context of an organization that must report specific clinical data to maintain funding and which has its own internal procedures.

Patients' immediate needs in the context of organizational mandates.

Lack of time for patient encounters has been reported extensively as a health care organization factor for why sexual histories are not collected (Abdolrasulnia et al., 2010; Barber et al., 2011; Do et al., 2015; Haley et al., 1999; Khan et al., 2007; Lanier et al., 2014; Maes & Louis, 2011) and I have written in the previous chapter about the evolution of how patients schedule appointments and the time limits imposed on them at the LHC. I noted infrequently in my field notes that the LHC seemed busy. Conversely, I also noted how few patients informants saw during an episode of fieldwork or the low numbers of patients on informants' schedules for a particular day or portion of a day. At no point during fieldwork did I observe health care providers appearing to be overwhelmed by the number of patients on their schedules. I did not observe that informants were rushing through appointments. I did not record the amount of time spent in each encounter, but there were likely instances in which encounters lasted longer or shorter than the allotted fifteen minutes. It is impossible to say that I would have observed more sexual history taking if appointment times were longer; however based on the fieldwork I conducted, fifteen minute appointment times did not seem to be a barrier to sexual history taking per se. Rather, addressing patients' immediate needs and negotiating what was addressed

during visits likely consumed the allotted time for an appointment, forcing other concerns (and any type of history taking) to be relegated to future encounters.

The informants in my study managed patients' multiple medical concerns which must be addressed during encounters that are scheduled in short increments of time. In an effort to remain on schedule and provide adequate care, health care providers may have to abbreviate aspects of health care encounters, including history taking. In addition to addressing patients' medical needs, health care providers at the LHC noted that sometimes they needed to address patients' basic needs (e.g., obtaining food and housing). These health care providers are also providing care to patients who have mental health concerns, opioid dependence, and who have experienced trauma. These health care providers have come to use their allotted time with patients differently than traditionally structured encounters which, according to the published guidelines (Bickley & Szilagyi, 2007) usually begin with a chief complaint and end with a diagnosis and plan (although there were certainly encounters that I observed that had this structure). Health care providers at the LHC recognize that their goals for encounters may be replaced by requests from patients to address their other needs, and they use the time they have accordingly. Additionally by adapting how the encounters are conducted the health care providers did not talk about patients in terms of their diagnoses, but viewed them more fully as individuals with needs other than just the biomedical management of various concerns.

Given its designation as a FQHC the LHC is required to report yearly on several quality of care measures. With the exceptions of cervical and colorectal cancer screenings and HIV linkage to care, the remaining measures are not directly related to patients'

sexual health; although if uncontrolled, many have the potential to affect aspects of patients' sexuality. For example, tobacco use and uncontrolled cholesterol, hypertension, and diabetes may lead to erectile dysfunction; patients who screen positive for depression may have little interest in sex or may use sex to manage depression, leading to behaviors that may adversely impact their sexual health (Brawner, Gomes, Jemmott, Deatruck, & Coleman, 2012). Administrators and health care providers at FQHCs may focus their expertise and resources on meeting the mandated quality of care measures at the expense of other measures and medical concerns, including those more closely aligned with aspects of sexuality. Although I did not ask the informants in this study how the quality of care measures affect their daily clinical practice, the findings indicate that it is likely understood that they are important for reasons for procuring funding, but patients' immediate (and often basic) needs supplant those of federal mandates.

In addition to not directly comprehensively addressing sexual health and sexuality, none of the HRSA quality of care measures address the needs of many of the patients served by the LHC: homelessness and other social needs, drug dependence, experiencing trauma, and severe mental health concerns. All HRSA funded health centers, regardless of the number of patients served or their characteristics, report the same quality of care measures. For example, I randomly looked at the 2014 data from a health center in North Dakota (U.S. Department of Health and Human Services [HHS], 2016a) and found that it serves more than five times the patients as the LHC, yet only 12.2% of those patients are classified as homeless (compared to 79% of the patients seen at the LHC). However, the LHC is one of 268 grantees of the National Health Care for the Homeless Program (HHS, 2016b). Data from 2014 indicate that, combined, these

health centers serve 813,331 total homeless persons (HHS, 2016b). Using International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) and Current Procedural Terminology (CPT-4) codes, grantees of this program report additional information (other than the aforementioned HRSA quality of care measures) that more accurately reflects the patients served by the LHC, and more aspects of sexual health (HHS, 2016b).

In the context of my study, examining these aggregate data on diagnoses and diagnostics (from the National Health Care for the Homeless Program data) provides no information on what health history data (including sexual health data where applicable) health care providers obtained from patients during health care encounters in order to make these diagnoses and order these diagnostics. Examining and reporting the data collected and used by individual health care providers to substantiate a diagnosis and order diagnostics would be nearly impossible to collect and analyze, and may have little impact on national policy. However, this information would be valuable for organizations and individual health care providers who strive to improve the delivery of individualized care, like the LHC which has recognized the need for changing clerical, clinical, and environmental procedures to better meet the needs of the vulnerable individuals it serves.

Strengths

This research adds to the limited number of naturalistic studies exploring sexual history taking (Alexander et al., 2014; Bray et al., 2010; Gott et al., 2003; Gott et al., 2004; Poljski et al., 2003; Ports et al., 2014) and to my knowledge this is the first ethnographic study to explore this clinical practice behavior. Passive observation of patient-health care provider encounters was a unique way to study this phenomenon

which has been explored mostly through provider self-report and audits of health records. Self-report is subject to social desirability bias; health care providers may report higher rates of sexual history taking as well as more comprehensive content than are truly collected (Groves et al., 2009). In previous studies, audio-recordings of office visits have been used to explore sexual history taking (Alexander et al., 2014; Ports et al., 2014). Although this method for data collection may minimize or eliminate social desirability bias associated with self-administered questionnaires (and the time-intensive nature of engagement in fieldwork) it fails to capture all elements of an encounter between patients and health care providers, including the positioning of those in the room, nonverbal communication patterns, eye contact, and the use of an EHR (all things that I observed and recorded in my field notes). Having the ability to directly observe these behaviors through my research offers a unique perspective on this practice behavior. My study provides an important contribution, focused on an extremely vulnerable patient population, and is consistent with recommendations that studies directly observe communication between patients and their health care providers (Alexander et al., 2014).

Another strength of my study is the use of IRB-approved deception/incomplete disclosure. If informants knew that I was exploring sexual history taking specifically they may have altered this practice behavior. I feel confident that my presence in the examination room did not significantly impact informants' practice behaviors. Specifically, my prolonged and in-depth engagement with the LHC (Morse, 2015) facilitated informants' comfort with my presence during data collection. In addition, even when informants understood the study purpose to be "general history taking" I did not observe their practice behaviors to change (e.g., informants did not add or delete specific

aspects of health history taking such as past medical/surgical histories) based on my presence or the fact that the informant had enrolled in my study.

Boundaries

I acknowledge that with the small number of health care provider informants employed at the LHC there were less opportunities to observe sexual history taking. Had I conducted the study in a larger organization, or network of organizations, the prevalence of sexual history taking may have been higher and there may have been opportunities to explore and compare sexual history taking between health care providers. Additionally, I only observed 79 visits and only one was a wellness visit. I cannot assume that had I observed more wellness visits (during which the focus of the visits is broader compared to visits for specific medical concerns) that more sexual history data would have been collected. Given that I was not permitted to conduct fieldwork on Women's Health Days I was unable to observe whether this practice occurred more (or at all) during well woman visits. Throughout the duration of data collection, and particularly as passive observations of encounters became less frequent, I contemplated and considered whether observing 80 more encounters would yield instances of sexual history taking. I also considered whether I was missing a number of sexual histories being collected when I was not conducting fieldwork. However, given that the LHC operates with a same day scheduling policy it would have been difficult to determine which provider had more wellness visits scheduled on any particular day when I was choosing who to shadow during fieldwork.

Another potential boundary was the shorter duration of this study, although it is in keeping with focused ethnographic methodology (Boyle, 1994). I may have observed

more instances of sexual history taking had I remained in the field for several more months. This additional time would have allowed for subsequent one-on-one interviews with informants to occur; these could have been opportunities to explore informants' perspectives on sexual history taking as a practice, specifically within the LHC.

In conceptualizing and designing my study I chose not to collect data specific to individual patient-health care provider encounters from the LHC's EHR. Doing so would have allowed me to see if and when sexual histories were documented in individual patients' records previously. For example, even though I may not have observed the collection of sexual history data during a particular encounter, having access to the EHR would have allowed me to look back at a patients' previous encounters, showing me that a comprehensive sexual history was (or was not) documented during an encounter three week prior.

Implications

Education.

Health care providers have reported that they lack, or had inadequate, training in sexual history taking (Abdolrasulnia et al., 2010; Barber et al., 2011; Do et al., 2015). Efforts to expose trainees in the health professions to sexual history taking, both in terms of commonly referenced, biomedically-based guidelines as well as potentially alternative approaches early in their education and continuing throughout their didactic and clinical experiences is recommended. This type of approach is consistent with my study findings that within a practice setting, unique aspects of the patient population, as well as the overall cultural context of the setting and provider mix impact what trainees need to understand to be able to provide optimal, truly patient-centered care. Equally important,

students and trainees should understand that sexuality, sexual behaviors, and sexual health are important aspects of patients' lives that continue throughout the lifespan, even in the face of multiple medical and psychosocial co-morbidities. Becoming comfortable with collecting sexual histories from persons of different ages and sociocultural backgrounds and acknowledging commonly held stereotypes (e.g., that housing insecure persons/those with opioid dependence may or may not be sexually active or have a greater or decreased risk of acquiring a STI) may increase the incidence of sexual history taking. Trainees should have access to practicing professional mentors who are comfortable discussing sexuality and obtaining sexual histories from patients.

Practice.

The National Health Care for the Homeless Council provides several adapted clinical guidelines for homeless patients, including general recommendations for caring for those that are homeless. This guideline recommends asking about “gender identity, sexual orientation, behaviors, partners, pregnancies, hepatitis/HIV/other STIs” (Bonin et al., 2010, p. ix). Health care providers who care for patients that are homeless should be familiar with these guidelines and should expand the sexual history to address other aspects of sexuality when appropriate. The findings from my study, however, indicate that despite the availability of such clinical guidance, the realities of day-to-day practice (occurring within a specific cultural context) necessitate further adaptation, and even deviance, from existing guidelines.

The adapted clinical guidelines from the National Health Care for the Homeless Council may also be useful for health care providers in ways other than just taking sexual histories. After reviewing the guidelines health care providers may reflect on their own

practices, noting that they have limited knowledge about diagnosing and treating concerns that affect aspects of patients' sexuality. As a result, health care providers may then seek opportunities to gain knowledge in these areas either through consultations with colleagues or other self-learning activities. Furthermore, health care providers who consider patients' sexual health expand their repertoire of health maintenance and preventive health care topics beyond, for example, age-appropriate cancer screenings and education regarding healthy diets and exercise.

Research.

This dissertation has generated a number of additional research questions; addressing them would expand and propel the existing body of knowledge on sexual history taking, particularly for vulnerable populations, such as those receiving care at the LHC. For example, guidelines that currently exist for the type of information to include in a sexual history include varied or non-existent operational definitions (Banas et al., 2010) that may or may not be useful in a population such as the patients receiving care at the LHC. Moreover, at least one recent study only addressed documentation of discussions about anal or oral sex (Menon-Johansson et al., 2014), yet many other content areas (e.g., the use of birth control) may be important to explore. Thus, it is recommended that future studies explore how health care providers within varied settings define sexual health, and collect, use, and evaluate sexual histories while embracing the specific needs of the patient population.

A second area for future research is related to incorporation of the EHR as an additional data source. In so doing, a group of patient participants could be recruited and followed longitudinally during all of their health care encounters in a given timeframe

(e.g., six months). This would provide additional triangulation and facilitate a broader view of what happens both during an actual encounter and as providers use existing mandated documentation models to include (or not include) important aspects of a primary care visit, including sexual health.

A third area for inquiry involves combining data collection methods (e.g., chart reviews with audio recordings) to compare what is discussed in an encounter with what is actually documented in the EHR during/after the encounter. For example, health care providers may be eliciting sexual histories but are not documenting them; alternately, sexual histories may be documented when they did not occur. Studies such as these, using a mixed methods approach, would contribute to the literature on the utility of EHRs during health care encounters if they demonstrate that they enhanced the collection and documentation of sexual health data. Additionally, such studies may have financial and policy implications if discrepancies exist between what actually occurs during an encounter and what is documented in the EHR.

More than anything else I hoped that this study would provide a detailed and rich description of how health care providers evaluate and use sexual history data after they were collected. Instead, a focused ethnographic approach allowed a much broader examination and rich description of how providers and patients collaborate to address individual and population-based needs with the context of organizational mandates. Future studies should build on the findings of this study and continue to move this area of scholarship further along a continuum of addressing patients' sexual health (including risks for adverse sexual health outcomes) and incorporating treatment strategies that are consistent with maintaining or enhancing patient and community-focused goals.

Conclusions

A key finding from this study is that the LHC and its staff recognize and meet the needs of the patients they serve. Evidence of this are the multiple changes that have occurred, most of which are examples of the collaborative interactions between patients and health care providers with a context of administrative support. Examples include changes in how patients schedule appointments, starting a medication assisted treatment program for patients with opioid dependence, attempting to increase cervical cancer screening through quarterly Women's Health Days, integrating behavioral health and primary care, and implementing software to assist with quality improvement initiatives. More recently health care providers have recognized that many of the patients seen at the LHC are infected with hepatitis C. The health care providers plan to begin treating these infections, rather than referring patients to specialists for treatment. These practice changes are the result of recognizing that patients at the LHC have needs that may differ from those of patients seen in other primary care practices and the willingness to implement them to provide the care that patients need.

APPENDIX A

Key Informant Characteristics

Name:

Professional title:

Highest level of education (e.g., DNP, DO, MD, MS, MSN, PhD):

Years in clinical practice in your current professional role (e.g., number of years you have been a nurse practitioner or physician):

Years in practice at this location:

Please choose a pseudonym (i.e., first name only):

APPENDIX B

Interview Guide – 8/27/15

Introduction to the interview:

Thank you for agreeing to participate in this interview today. Before we begin, I just want to remind you of the purpose of this research project: to learn more about how health care providers collect, evaluate, and use health history information during the course of health care encounters with clients/patients. You should know that I use “health care providers” to describe persons who provide health related services to clients/patients, not just physicians.

Over the past few months I have learned a lot about the organization as a whole, the clients/patients, and the staff and providers. Based on the observations I have made so far, and informal conversations with providers and other staff members, I’ve come up with a few questions I would like to explore in more detail. I would like to learn more about you, your role within the organization, and how you think about your practice and your clients/patients.

Informant	Question	Probe(s)
<u>Medical & Social providers</u>	Tell me about your role in this organization.	Talk with me about what this role means to you, personally and professionally.
		Tell me about some factors that make it easy for you to fulfill this role. Tell me about some of the challenges you face in your current role.
	Tell me what a typical day at work here in the office is like for you.	Tell me about your routine at work. Tell me about the control you have over your day. You might think of the structure of your visit schedule. For example, of the different types of

	patient visits, like acute or preventive. I know that the office does same day scheduling. Tell me about how this impacts your day. Talk to me about your feelings about the new building verses the old building.
Tell me about your philosophy of the way you practice or provide care.	Talk with me about events, people, or other personal or professional experiences that influence how you think about and practice medicine/social work. Talk with me about your spiritual or religious beliefs and how they influence how you think about and practice medicine/social work.
In an ideal world, tell me about the way you would like to practice or provide care.	Tell me what your ideal job as a provider looks like. Tell me about changes you'd make in your current position that would make your work more fulfilling.
Tell me about the clients/patients that visit this practice.	Tell me about their most common medical/social concerns.

		Tell me about what you think they need most from you to help them improve or maintain their health. Tell me about what you think are their expectations of you as a provider.
	Tell me about ways that you build and maintain relationships with clients/patients.	Tell me about your interactions with clients/patients. Tell me about a client/patient that you feel you have a strong relationship with. Tell me about a client/patient that you'd rather not see again.
	Tell me about your interactions with your co-workers. Tell me about your interactions with the administrators.	Talk to me about your perception of the role the medical assistants play in helping you to care for clients/patients (<i>Probe for medical providers only</i>).
<u>Medical providers only</u>	I've noticed that the reason for many clients'/patients' visits is to address acute concerns. I'd like to know more about your approach to different types of visits. Tell me about your	Tell me about how you conduct visits for different types of concerns (i.e., acute vs. chronic vs. wellness).

	approach to visits for acute concerns. Tell me about your approach to visits for chronic concerns. Tell me about your approach to prevention/wellness visits.	Tell me about a specific example or event that sticks out in your memory (for each type of visit).
<u>Social providers only</u>	I'd like to know more about why clients/patients are referred to you. Tell me about the reasons why clients/patients come to meet with you.	

APPENDIX C

Interview Guide

I. Sexual history collection

- a. When do you take a sexual history?
- b. How did you learn to take a sexual history?
- c. What is your definition of a sexual history?
- d. When taking a sexual history, what types of information do you want to know?
- e. What factors do you consider when you decide to (or not to) take a sexual history?
- f. What is it about the patient or the type of visit that makes you either take or not take a sexual history?
- g. Describe a patient that you would want to take a sexual history from.
- h. Describe a patient that you would not want to take a sexual history from.
- i. Are there types of patients that you always take a sexual history from?
- j. Are there types of patients that you never take a sexual history from?
- k. Describe a positive experience you have had when taking a sexual history.
- l. Describe a negative experience you have had when taking a sexual history.

II. Sexual history evaluation

- a. How do you interpret the information you collect using a sexual history?
- b. How do you determine a patient's risk for having a negative sexual health outcome based on her or his sexual history?
- c. How do you decide that a patient's sexual practices are not risky or are risky?
- d. What types of patients do you think practice risky sexual behaviors?
- e. What characteristics of patients make you think that they are not at risk to have a negative sexual health outcome?

III. Sexual history use

- a. How do you use the information you collect during a sexual history?
- b. Describe an instance when you used information from a sexual history to help you make an assessment of a patient and plan for her or his care?
- c. What types of patients would benefit from having a sexual history taken?
- d. What types of patients would not benefit from having a sexual history taken?

APPENDIX D

University of Pennsylvania
Office of Regulatory Affairs
3624 Market St., Suite 301 S
Philadelphia, PA 19104-6006
Ph: 215-573-2540/ Fax: 215-573-9438
INSTITUTIONAL REVIEW BOARD
(Federalwide Assurance # 00004028)

14-May-2015
(Revised 22-Apr-2016)

Christine K. Bradway
CWB@NURSING.UPENN.EDU
nowicki@nursing.upenn.edu

PRINCIPAL INVESTIGATOR	: Christine K. Bradway
TITLE	: The Collection, Evaluation, and Use of Health Histories in Federally Qualified Health Centers
SPONSORING AGENCY	: NO SPONSOR NUMBER
PROTOCOL #	: 822424
REVIEW BOARD	: IRB #8

Dear Dr. Bradway:

The above referenced protocol was reviewed and approved using the expedited procedure set forth in 45 CFR 46.110, category 6,7, on 13-May-2015. This study will be due for continuing review on or before 12-May-2016.

Approval by the IRB does not necessarily constitute authorization to initiate the conduct of a human subject research study. Principal investigators are responsible for ensuring final approval from other applicable school, department, center or institute review committee(s) or boards has been obtained. If any of these committees require changes to the IRB-approved protocol and informed consent/assent document(s), the changes must be submitted to and approved by the IRB prior to beginning the research study.

If this protocol involves cancer research with human subjects, biospecimens, or data, you may not begin the research until you have obtained approval or proof of exemption from the Cancer Center's Clinical Trials Review and Monitoring Committee.

NOTE: The IRB reviewed and approved the use of deception allowing for the waiver or alteration of the required elements of consent under § 46.116(d) as it was determined that (1) the study is no greater than minimal risk, (2) conducting the study would be impracticable without the waiver, (3) waiving does not adversely affect subjects and, if applicable, (4) pertinent information will be provided to the subjects later.

NOTE: The IRB reviewed and approved the Subpart B review as per Federal Regulations 45 CFR 46.204 (a)-(j). The IRB determined that each condition was met or determined not to be applicable for this proposed research.

NOTE: The IRB reviewed and approved the Subpart D review as per Federal Regulations 45 CFR 46.404 (FDA 50.51), as the research was determined to be no greater than minimal risk. The IRB determined that permission of one parent is sufficient and that adequate provisions are made for soliciting permission. The IRB has determined that assent must be obtained from subjects and appropriately documented.

The following documents were included in this review:

- HS ERA Initial Application, confirmation code: b1b1c1fd, submitted 5.12.15
- Cover Letter, dated 5.6.15
- Informed Consent Form, uploaded 5.6.15
- Letter of Support, dated 3.18.15
- Assent Form, uploaded 4.16.15
- Key Informant Characteristics Questionnaire, uploaded 4.16.15
- Interview Guide, uploaded 4.16.15
- Vulnerable Populations Pregnant Woman, Fetuses and Neonates Form, uploaded 4.15.15
- Vulnerable Populations Children Form, uploaded 4.15.15

When enrolling subjects at a site covered by the University of Pennsylvania's IRB, a copy of the IRB approved informed consent form with the IRB approved form's stamp must be used unless a waiver of written documentation of consent has been granted.

If you have any questions about the information in this letter, please contact the IRB administrative staff. Contact information is available at our website: <http://www.upenn.edu/IRB/directory>.

Thank you for your cooperation.

Sincerely,

David
Heagerty

Digitally signed by
David Heagerty
Date: 2016.04.22
10:12:41 -04'00'

IRB Administrator

University of Pennsylvania
Office of Regulatory Affairs
3624 Market St., Suite 301 S
Philadelphia, PA 19104-6006
Phone: 215-573-2540/ Fax: 215-573-9438
INSTITUTIONAL REVIEW BOARD
(Federal-wide Assurance # 00004028)

08-Sep-2015

Christine K. Bradway
CLAIRE M. FAGIN HALL
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Timothy Sowicz
tsowicz@nursing.upenn.edu

PRINCIPAL INVESTIGATOR	: CHRISTINE K. BRADWAY
TITLE	: The Collection, Evaluation, and Use of Health Histories in Federally Qualified Health Centers
SPONSORING AGENCY	: NO SPONSOR NUMBER
PROTOCOL #	: 822424
REVIEW BOARD	: IRB #8

Dear Dr. Christine Bradway:

The documents noted below, for the above-referenced protocol, were reviewed using the expedited procedure set forth in 45 CFR 46.110 and approved on 9/3/2015.

The following documents are included:

- _HSERA Modification Submission (confirmation code: bijjfbic) Submitted on: 8-27-15
- _Interview Guide, dated 8-27-15
- _Key Informant Characteristics, uploaded 8-27-15
- _Revised Informed Consent Form, uploaded 9-08-15

If you have any questions about the information in this letter, please contact the IRB administrative staff. Contact information is available at our website: <http://www.upenn.edu/IRB/directory>.

Thank you for your cooperation.

Sincerely,

Kelly
McGeehan
IRB Administrator

Digitally signed by Kelly McGeehan
DN: cn=Kelly McGeehan, o=ORA,
ou=IRB,
email=mcgkell@upenn.edu, c=US
Reason: I attest to the accuracy and
integrity of this document
Date: 2015.09.08 10:46:13 -04'00'

APPENDIX E

Informed Consent

Title of the Research Study: The Collection, Evaluation, and Use of Health Histories in Federally Qualified Health Centers

Protocol Number:

Principal Investigator: (name, address, phone and email)

Christine K. Bradway, PhD, RN, CRNP, FAAN

University of Pennsylvania School of Nursing

Claire M. Fagin Hall Room 312

418 Curie Boulevard

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You are being asked to take part in a research study. This is not a form of treatment or therapy. It is not supposed to detect a disease or find something wrong. Your participation is voluntary which means you can choose whether or not to participate. If you decide to participate or not to participate there will be no loss of benefits to which you are otherwise entitled. Before you make a decision you will need to know the purpose of the study, the possible risks and benefits of being in the study and what you will have to do if decide to participate. The research team is going to talk with you about the study and give you this consent document to read. You do not have to make a decision now; you can take the consent document home and share it with friends, family doctor and family.

If you do not understand what you are reading, do not sign it. Please ask the researcher to explain anything you do not understand, including any language contained in this form. If you decide to participate, you will be asked to sign this form and a copy will be given to you. Keep this form, in it you will find contact information and answers to questions about the study. You may ask to have this form read to you.

IRB Approved: 03-Sep-2015 To: 12-May-2016

What is the purpose of the study?

The purpose of the study is to learn more about how health care providers collect, evaluate, and use health history information during the course of health care encounters with clients/patients. This study is being conducted for a doctoral dissertation.

Why was I asked to participate in the study?

You are being asked to join this study because you are a licensed health care provider in a federally qualified health center who has had training in taking health histories.

How long will I be in the study?

The study will take place over a period of six months. This means for the next six months we will ask you to spend zero to eight days a month participating in this study. Each session will last approximately 4 hours.

Where will the study take place?

You will be asked to come to Project H.O.P.E., Inc. Bergen Lanning Health Center, located at 439 Clinton Street, Camden, NJ, 08102 during your regularly scheduled work week. Additional time will be required for individual, in-person interviews with you. These interviews will last approximately one hour and the date, time, and location for them will be agreed upon by you and the researcher.

What will I be asked to do?

- You will be asked to allow the researcher to observe health care encounters between you and your client/patients during your normal work schedule.
- You will be interviewed at least once during the course of the study. Each interview will last approximately one hour.

What are the risks?

- There is a risk of a breach of confidentiality. If such a breach occurs, this could entail critique of your individual clinical practices from colleagues and supervisors and public embarrassment. To minimize this risk, you will choose a pseudonym which will be used to identify you. Only the researcher will have access to the form linking your real name to your pseudonym. The paper copies of these forms will be stored in a lock box that only the researcher will have access to. These paper forms will then be scanned and stored on a password protected, encrypted external hard drive, at which time the paper forms will be destroyed. The information gathered during the study will not be used to describe individual health care provider's practices, and such practices will not be discussed with provider's colleagues or supervisors.

How will I benefit from the study?

There is no benefit to you. However, your participation could help us understand how information gathered from health histories is used in clinical practice, which can benefit you indirectly. In the future, this may help other people to enhance their health history taking ability.

IRB Approved: 03-Sep-2015 To: 12-May-2016

What other choices do I have?

Your alternative to being in the study is to not be in the study.

What happens if I do not choose to join the research study?

You may choose to join the study or you may choose not to join the study. Your participation is voluntary.

There is no penalty if you choose not to join the research study. You will lose no benefits or advantages that are now coming to you, or would come to you in the future. No one will be upset with your decision.

If you are currently receiving services and you choose not to volunteer in the research study, your services will continue.

When is the study over? Can I leave the study before it ends?

The study is expected to end after all participants have completed all visits and all the information has been collected. The study may be stopped without your consent for the following reasons:

- The PI feels it is best for your safety and/or health-you will be informed of the reasons why.
- You have not followed the study instructions
- The PI, the sponsor or the Office of Regulatory Affairs at the University of Pennsylvania can stop the study anytime

You have the right to drop out of the research study at any time during your participation. There is no penalty or loss of benefits to which you are otherwise entitled if you decide to do so. Withdrawal will not interfere with your future care.

If you no longer wish to be in the research study, please contact Timothy Sowicz, at 617-470-9754. You can simply tell Timothy that you no longer wish to be in the study, and there will be no consequences for withdrawing from the study.

How will confidentiality be maintained and my privacy be protected?

We will do our best to make sure that the personal information obtained during the course of this research study will be kept private. However, we cannot guarantee total privacy. Your personal information may be given out if required by law. If information from this study is published or presented at scientific meetings, your name and other personal information will not be used.

- Confidentiality will be maintained through the use of pseudonyms, which will be used to identify you. Only the researcher will have access to the form linking your real name to your pseudonym. The paper copies of these forms will be stored in a lock box that only the researcher will have access to. These paper forms will then be scanned and stored on a password protected, encrypted external hard drive, at which time the paper forms will be destroyed. The information gathered during the study will not be used to describe individual health care provider's

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practices, and such practices will not be discussed with provider's colleagues or supervisors. The IRB at the University of Pennsylvania will have access to the records.

What happens if I am injured from being in the study?

We will offer you the care needed to treat injuries directly resulting from taking part in this research. We may bill your insurance company or other third parties, if appropriate, for the costs of the care you get for the injury, but you may also be responsible for some of them.

There are no plans for the University of Pennsylvania to pay you or give you other compensation for the injury. You do not give up your legal rights by signing this form.

If you think you have been injured as a result of taking part in this research study, tell the person in charge of the research study as soon as possible. The researcher's name and phone number are listed in the consent form.

Will I have to pay for anything?

- There are no costs associated with participating in the study.

Will I be paid for being in this study?

- There is no compensation for participation in this study.

Who can I call with questions, complaints or if I'm concerned about my rights as a research subject?

If you have questions, concerns or complaints regarding your participation in this research study or if you have any questions about your rights as a research subject, you should speak with the Principal Investigator listed on page one of this form. If a member of the research team cannot be reached or you want to talk to someone other than those working on the study, you may contact the Office of Regulatory Affairs with any question, concerns or complaints at the University of Pennsylvania by calling (215) 898-2614.

When you sign this document, you are agreeing to take part in this research study. If you have any questions or there is something you do not understand, please ask. You will receive a copy of this consent document.

Signature of Subject

Print Name of Subject

Date

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APPENDIX F

ASSENT TO PARTICIPATE IN RESEARCH

Understanding how Your Health Care Provider Collects Information from You during Your Visit

1. My name is Timothy Sowicz. I am a nurse and a student at the University of Pennsylvania.
2. We are asking you to take part in a research study because we are trying to learn more about how your health care provider collects information from you and how they use that information to make decisions with you about your health care.
3. If you agree to be in this study that means that you will let me be in the exam room with you when you talk to your provider today. I will not ask you questions when I am in the room. I will just be there to watch and listen to how you and your provider talk to each other. I will not talk about what was said in the exam room with any other person, including your parent(s) or guardian(s).
4. One risk is that I may overhear you talking to your provider about personal issues. I will not talk to anyone else about what you tell your provider.
5. By agreeing to be in the study, you can help us to better understand how health care providers talk to people and make decisions with people about their health.
6. Please talk this over with your parent(s) or guardian(s) before you decide whether or not to participate. We will also ask your parents to give their permission for you to take part in this study. But even if both of your parents or guardians say “yes” you can still decide not to be in this study.
7. If you don’t want to be in this study, you do not have to participate. Remember, being in this study is up to you and no one will be upset if you don’t want to participate or even if you change your mind later and want to stop.
8. You can ask any questions that you have about this study. If you have a question later that you didn’t think of now, you can call me at 617-470-9754 or ask me the next time you see me.
9. Signing your name below means that you agree to be in this study. You and your parents will be given a copy of this form after you sign it.

Participant

Date

Investigator

Date

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