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Florida Public Health Review

Volume 13 Article 17

2016

Practice Patterns for Sexual History-taking among Florida Nurses

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ABSTRACT

Florida has some of the highest reported sexually transmitted disease (STD) rates in the country. STDs are a particular problem for minorities, women, and adolescents. Sexual history elicitation is a tool available to clinicians to assess patients' sexual risk behaviors and to counsel, test, and treat STDs. Nurses play an important role in caring for patients' sexual health problems, including unwanted pregnancies and STDs. We examined the sexual history-taking practices among advanced registered nurse practitioners (ARNPs) in Florida. We mailed an anonymous pencil-and-paper survey to measure sexual history-taking practices to a stratified random sample of 795 ARNPs. We analyzed the data with SPSS. Overall, 185 ARNPs completed the survey (23% response rate). We found that sexual history-taking practices varied. Approximately 71% of Florida ARNPs reported taking sexual histories. Targeted interventions are needed to increase sexual history-taking practices.

Florida Public Health Review, 2016; 13, 137-142.

BACKGROUND

Sexually transmitted diseases (STDs) are a hidden epidemic of tremendous health and economic consequences in the United States (U.S.). They are hidden from public view because many Americans are reluctant to address sexual health issues in an open way and because of the biological and social factors associated with these diseases (Institute of Medicine [IOM], 1997). The 2013 Centers for Disease Control and Prevention (CDC) STD surveillance report estimated that approximately 20 million new infections occur each year and that racial disparities exist in the two most common reportable STDs, chlamydia and gonorrhea, with African Americans and women bearing the greatest burden. This report also estimated that STDs cost the U.S. healthcare system $15.3 billion annually. In 2013, over one million cases of chlamydia were reported to the CDC (CDC, 2013).

Florida is the third most populated state in the U.S. with an estimated population of 19.9 million (U.S. Census Bureau, 2014). Florida has a large HIV/AIDS health disparity. In 2013, an estimated 5,364 adults and adolescents were diagnosed with HIV in Florida. Florida ranked 1st among the 50 states in the number of HIV diagnoses in 2013. In 2014, Florida reported 111,240 cases of STDs; 84,194 chlamydia, 20,944 gonorrhea, and 6,102 syphilis (CDC, 2015).

Several STDs cause serious health problems, such as infertility, genital cancers, increased risk for HIV infection and other chronic diseases and death (Tao, Irwin, & Kassler, 2000). The frequently asymptomatic nature and the potential for severe complications of untreated STDs call for targeted efforts to identify, treat, and prevent disease among those at greatest risk. Sexual history-taking, counseling, and education are excellent tools available to clinicians for such efforts, and serve to reduce provider bias and assumptions regarding client risk behaviors or lack thereof. Earlier studies have shown inconsistencies regarding STD evaluation by primary care clinicians and physicians. However, the literature regarding the consistency of practice patterns regarding elicitation of sexual history is limited (Bull, Reitmeijer, Fortenberry, Stoner, & Malotte, 1999).

Assessment of STD risk should be based on careful analysis of sexual history, drug use history, and consideration of the local epidemiology of STDs. Sexual history should include questions about number and nature of current and past sex partners (including same-sex partners or partners who have injected drugs), any history of past STD infections, the use of condoms or other barrier protection, and particular high-risk sexual practices such as anal intercourse (USPSTF, 1996). The CDC's guide to

taking a sexual history recommends the 5 "P"s of sexual health: partners, practices, protection from STDs, past history of STDs and prevention of pregnancy (CDC, 2015).

The sociocultural taboos related to sexuality are a barrier to STD prevention efforts on a number of levels. Effective STD prevention efforts also are hampered by biological characteristics of STDs, societal problems, unbalanced media messages, lack of awareness, fragmentation of STD-related services, inadequate training of healthcare professionals, inadequate health insurance coverage, and access to services and insufficient investing in STD prevention (IOM, 1997). Barriers and inconsistencies in sexual history taking are a missed opportunity for improved STD assessment and prevention.

Providers are the first line of defense. Routine medical check-ups provide a regular opportunity for healthcare providers to assess patients' risky sexual behaviors, to counsel them to reduce such behaviors, to screen, and diagnosis STDs and to treat infected patients (Tao et al., 2000).

Role of Nurses in Sexual Healthcare

Sexuality is basic to our personal physical, mental, psychological, emotional, and ethical well-being as well as to interpersonal relationships. People are sexual beings at every age and at all stages of development. As people grow and develop they encounter a variety of experiences with implications for their sexuality and these can be severely affected by ill health and medical treatment. Nurses are ideal members of the healthcare team to counsel patients in the sensitive and highly charged area of human sexuality. Providing patients with information concerning their sexual health and related treatment to enhance their quality of life outcomes is an important task for nurses. Unfortunately, sexuality is still not openly discussed, nursing clinical pathways seldom reflect an attention to a person's sexuality, and nurses do not routinely inquire about their patients' sexual practices nor provide teaching or counseling in the area (Sung & Lin, 2013). All patients have potential sexuality and sexual health needs. This is part of holistic care and nurses cannot ignore the care of client's sexual health needs. Nurses play a more important role in caring for clients with sexual health problems, including pregnancy and STD prevention (Kong, Wu, & Loke, 2009).

Diversity in Nursing

Nationally approximately 83% of all RNs are Caucasian; 6% are African-American; 6% are Asian or Pacific Islander; 3% are Hispanic; 0.5% are American Indian or Alaska Native; and 1% categorize themselves as "multiracial." Minorities make up 37% of the U.S. population but are severely underrepresented in the nursing profession (American Association of College of Nursing, 2016). In Florida, the demographic composition of nurses is distinctly different from Florida's population overall. The nursing profession in Florida has historically been comprised predominantly of white women. In contrast, Florida's population is racially and ethnically heterogeneous, and is projected to increase in diversity (Florida Center for Nursing, 2015). Statewide, 70.5% of RNs working were white, 12.0% were black, and 8.3% were Hispanic in 2010. Whites also accounted for 79.5% of ARNPs and 58.5% of LPNs in 2010 (Florida Center for Nursing, 2015). The healthcare workforce and its ability to deliver quality care for racial and ethnic minorities can be improved substantially by increasing the proportion of underrepresented racial and ethnic minorities among health professionals (IOM, 2003). A diverse healthcare workforce is critical to reducing health disparities including STDs and HIV which overwhelmingly impact minorities and women. The purpose of our study was to examine the sexual history-taking practices of Florida's ARNPs

METHODS

Sample

The population of interest for this study was active, practicing ARNPs in (obstetrics and gynecology, internal medicine, family practice, pediatrics) residing in the state of Florida. A random stratified sample of ARNPs (estimated N = 795) was selected from a sampling frame of 11,910 ARNPs obtained from the Florida Department of Health Division of Medical Quality Assurance. Stratification was by ARNP profession classification, not setting or geographic location.

Instrument

An anonymous pencil-and-paper, self-administered survey was used in this study. The instrument, consisting of 23 questions and seven demographic questions, was constructed and tested to measure primary care provider sexual history-taking practices, as well as skills and comfort level with taking a sexual history. Demographic questions included ARNP gender, race, and age, specialty, and length in practice, practice location and medical training location. Survey questions were based on constructs from the Theory of Planned Behavior (Ajzen, 1985) and a review of the literature as well as questions adapted from the Gonorrhea Community Action Project, funded by the Centers for Disease Control and Prevention and the National Institute of Mental Health (VanDevanter, Messeri, Middlestadt, Bleakley, Merzel et al., 2005).

The survey consisted of four multi-item scales to measure ARNP sexual history-taking attitudes and behaviors using a 5-point Likert scale from

1=strongly agree, 2=agree, 3=I'm not sure, 4=disagree, 5=strongly disagree, and their likelihood of taking a sexual history (asking specific questions) 1=extremely not likely, 2=not likely, 3=likely, 4=extremely likely, and 5=I already do.

Data Collection

Data collection took place April and August 2010. The sample was solicited by mailed questionnaire in three waves. The first wave was a mail-out package containing a cover letter, consent form, questionnaire, and a stamped preaddressed envelope. All surveys were number-coded to allow for additional mail outs to non-responders. To ensure confidentiality, no names were used to identify respondents. Approximately two weeks after the first mail-out, reminder postcards were sent to those who had not responded, and two weeks after the reminder postcard a follow up reminder email was sent out. A 12-week window was allotted for providers to return the survey. In addition to the stamped preaddressed envelope, the respondents were given a link to the survey online at www.surveymonkey.com in an effort to increase the response rate.

RESULTS

Overall, 185 ARNPs (23%) completed the survey. Data in Table 1 show that the majority of respondents were white (67%). Table 2 shows that most of the ARNPs were women (85%), had been practicing over 10 years (72%), were over 45 years of age (68%), and practiced in a private group setting (25%). Fifty-four percent of nurses reported diagnosing 1-25 STDs per month. A completed survey was returned from 43 (out of 67) Florida counties. Three counties had 5 or more surveys completed: Leon, Miami-Dade and Duval. Reasons for non-response included retirement, deceased, non-provision of primary care, and bounced emails (opted out of Survey Monkey).

ARNPs were most likely to ask patients about their history of STDs, condom use, and injection drug use (Table 3). However, providers were less likely to ask questions about anal and oral sex which had the lowest means (M=3.14, 3.27 respectively). This finding is important because STDs can also be acquired via oral and anal sex. Anal sex is considered a high-risk sexual behavior because the lining of the rectum is thin and may allow viruses and bacteria to enter the body during anal sex. There have been misconceptions about the risk of oral sex and STDs. However, HIV, herpes, syphilis, gonorrhea, genital warts and hepatitis A all can be transmitted through oral sex (CDC, 2013).

Additionally, each ARNP received a score of 1-5 for likelihood to take a sexual history. This represents the average of the seven likelihood questions. A score of 3 or greater was coded as likely to take a sexual history and a score of less than 3 was coded as not likely to take a sexual history. Out the 158 ARNPs who completed all seven questions, the results showed that 112 (71%) reported taking a sexual history.

Of the ARNPs who disagreed or were not sure of having the skills, training, or time to take a sexual history, 63% responded that they were "not likely" to take a sexual history. Additionally, of the ARNPs who disagreed or were not sure that sexual history taking was an important tool or that it was a provider's duty to take a sexual history, 62% responded that they were "not likely" to take a sexual history. Furthermore, those that lacked the confidence or willingness to take sexual histories were also "not likely" to do so. Although most ARNPs agreed that there were difficulties taking a sexual history based on client disposition – clients get emotional, reluctant to talk about STDs, reluctant to change, or resistant to discuss STDs, 71% responded they were "likely" to take a sexual history.

Barriers associated with decreased likelihood to take a sexual history included ARNP skills, training, time, confidence, willingness and negative views on sexual history elicitation as an important tool. Similar to what Bull et al. (1999) report, difficulty with client disposition was not a barrier to taking a sexual history.

DISCUSSION

We found that 71% of Florida ARNPs reported taking sexual histories from their patients. It is possible that of those who reported not taking a sexual history, some may work in practice settings such as pediatrics or geriatrics with patients who do not require a sexual history. Fifty-six percent of ARPNs reported receiving additional STD training beyond their degree. Education is essential to improving the skills, knowledge, and ability of nurses to offer patients holistic care that includes a focus on sexual health. Based on the results of this study, possible targeted programs for Florida ARNPs include:

- Partnerships between the Florida Department of Health, institutions of higher learning, Area Health Education Centers (AHEC), community colleges, and continuing education programs to educate and train providers;
- Targeted interventions to increase sexual history taking among ARNPs;
- Use of technology for example electronic (via email) annual sexual history assessments such as those recommended by Tao et al. (2000);
- Emphasis on high risk sex (anal and oral) assessment in education and training of ARNPs;

Table 1
Race/Ethnicity Distribution of Florida ARNPs Responding to the Survey (N = 185)

	Number and (%)
Black/African American	29(16)
White	123(67)
Asian/PI	3(2)
Hispanic	12(7)
Native American	2(1)
Multicultural	2(1)
Other	5(3)

Table 2
Characteristics of Florida ARNPs (N = 185)

	Number and (%)
Gender	
Female	157 (85)
Male	21(11)
Length in Practice	
1-5 years	14(8)
5-10 years	34(18)
over 10 years	133(72)
Age	
under 25	1(.5)
26-35 years of age	7(4)
36-45 years of age	47(25)
over 45	126(68)
Medical Practice Type	
Private solo	24(13)
Private group	47(25)
MCO/HMO	6(3)
University teaching hospital	26(14)
Private hospital	6(3)
Community health center	12(7)
Publically funded clinic	22(12)
Other	40(22)
STD Diagnosis Per Month	
1-25	94 (54)
26-50	18(10)
50-100	5 (3)
Over 100	9 (5)

Table 3
Self-Reported Sexual History Elicitation Questions

How likely are you to ask patients about their…

	Mean	Extremely not likely	Not likely	Likely	Extremely Likely	I already do
Number of sex partners	3.48	7%	19%	29%	10%	35%
Sexual orientation	3.40	7%	19%	31%	14%	29%
History of STDS	3.76	5%	11%	23%	22%	38%
Condom use	3.75	6%	12%	22%	22%	38%
Engagement in oral sex	3.27	8%	24%	30%	12%	27%
Engagement in anal sex	3.14	9%	28%	26%	14%	23%
Injection drug use	3.54	7%	14%	27%	22%	30%
Mean Range 1-5						

- Use of health educators in medical practice setting such as mentioned by Yarnall et al. (2003);
- More funding for nursing programs (to increase enrollment);
- Programs to increase the diversity among Florida nurses; and
- Retention programs for current ARNPs.

Previous research has suggested specific actions to decrease barriers and inconsistencies in sexual health elicitation:

- Use of computer-based patient education tools that can facilitate sexual risk assessment and enhance provider-patient communication in busy MCO-based clinical practices (Choraba et al., 2004);
- Interventions with providers to standardize sexual history-taking and help to reduce barriers to prevention, diagnosis, and treatment of STDs (Bull et al., 1999);
- Interventions at the patient, provider, and community levels including developing innovative methods to obtain sexual histories such as through computer-assisted, self-administered patient questionnaires;
- Improving professional skills in sexual history-taking and behavioral risk reduction counseling (Tao et al., 2000);
- Instituting group visits with physicians and nurses, using health educators or dieticians for education and counseling (Yarnall et al., 2003); and
- Creating formal training programs or continuing education programs with modules devoted exclusively to the topic of sexual history elicitation for clinicians (Bull et al., 1999).

Limitations

This study relied on self-reported data from ARNPs which may pose various biases such as social desirability bias, exaggeration of behaviors, and a modest response rate. The research study was only conducted in Florida; therefore, the results may not be representative of other ARNPs in other states.

Conclusion

STDs are public health problems that lack easy solutions because they are rooted in human behavior and fundamental societal problems. Indeed, there are many obstacles to effective prevention efforts. A crucial step in prevention efforts is the need to improve sexual health training for nurses. Nurses are a critical component in the fight to reduce the STDs and HIV epidemic.

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