Addressing the Health of LGBT People through Public Health & Primary Care Collaboration

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Transforming Care: Midwest Conference on LGBTQ Health Equity and HIV/AIDS

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Disclaimer: The findings and conclusions in this presentation are those of the author and do not necessarily represent the official position of the Centers for Disease Control and Prevention/the Agency for Toxic Substances and Disease Registry.
Today’s Presentation

• CDC’s framework for collaborative work between public health and primary care
• The importance of addressing health disparities and equality for LGBT people, including collecting sexual orientation and gender identity (SOGI) information
• Current work by CDC’s HIV and STD prevention Divisions to improve the collection of SOGI and the provision of quality services to LGBT populations in community health centers
Changing Environment

– Increased insurance coverage
  • Uninsured 18-64 year olds down from 21% to 13%

– Payment Reform
  • Movement from fee-for-service to value-based
  • Value-focus may increase focus on prevention and wellness

– New Clinical Models
  • Patient-centered medical homes, FQHCs
  • ACOs – larger entities with vertical integrated care
Public Health Evolution

*Recession cuts unrestored – 46K fewer jobs
-48 % locals reduced PH services in 2012
-29 states decreased PH budgets in 2012

*Time of uncertainty & change
*Other cuts may come
*Attention to linkage with other sectors
Context: Numerous & Increasing STDs

Snapshot: STDs in the United States, 2015

Despite recent declines, 2015 was the second year in a row in which increases were seen in all three nationally reported STDs. The approximately 1.5 million cases of chlamydia represent the highest number of annual cases of any condition ever reported to CDC. Substantial increases were also seen among reported cases of gonorrhea and syphilis. While young people and women are most severely affected by STDs, increasing rates among men contributed to the overall increase in 2015 across all diseases.

**Chlamydia**
- Cases reported in 2015: 1,526,658
- Rate per 100,000 people: 479; increase of 6% since 2014

**Gonorrhea**
- Cases reported in 2015: 395,216
- Rate per 100,000 people: 124; increase of 13% since 2014

**Syphilis (primary and secondary)**
- Cases reported in 2015: 23,872
- Rate per 100,000 people: 8; 19% increase since 2014

**Syphilis (congenital)**
- Cases reported in 2015: 487
- Rate per 100,000 live births: 12; 6% increase since 2014
Primary Care & Public Health Collaboration

Three Buckets of Prevention

1. Traditional Clinical Prevention
   - Increase the use of evidence-based services

2. Innovative Clinical Prevention
   - Provide services outside the clinical setting

3. Total Population or Community-Wide Prevention
   - Implement interventions that reach whole populations

Health Care  Public Health

Why Focus on LGBT Health?

• The rate of new HIV diagnoses among MSM in the United States is more than 44 times that of other men (range: 522 – 989 per 100,000 MSM vs. 12 per 100,000 other men)\(^1\)

• Young, black MSM, in particular, are disproportionately affected, accounting for more new infections (4,800 in 2010) than any other subgroup\(^2\)

• HIV prevalence among African American trans women is approximately 56%, whereas the prevalence among Caucasian trans women is approximately 17%\(^3\)

• Compared to heterosexual adults, lesbian, gay, and bisexual individuals are more than twice as likely to smoke\(^4\)

• Lesbians and bisexual women are up to 10 times less likely than heterosexual women to undergo regular screening for cervical cancer\(^5\)

• Between 20 and 40% of homeless youth are LGBT\(^6\)
Increases in all STDs & STDs among MSM

Troubling rise in syphilis infections among men, particularly gay and bisexual men

Trend data show rates of syphilis are increasing at an alarming rate (19 percent in 2015). While rates have increased among both men and women, men account for more than 90 percent of all primary and secondary syphilis cases. Men who have sex with men (MSM)* account for 82 percent of male cases where the sex of the sex partner is known. Primary and secondary syphilis are the most infectious stages of the disease, and if not adequately treated, can lead to long-term infection which can cause visual impairment and stroke. Syphilis infection can also place a person at increased risk for acquiring or transmitting HIV infection. Available surveillance data indicate that an average of half of MSM who have syphilis are also infected with HIV.

Data on gender of sex partners was obtained through patient interviews among a random sample of gonorrhea cases reported 2010 through 2013 in jurisdictions collaborating in the STD Surveillance Network (SSuN, Fig 2). Case weights were developed, adjusted for non-response, and used to estimate the total number of male gonorrhea cases attributable to GBMSM by year for 2010 to 2013 in each collaborating jurisdiction.
Primary and Secondary Syphilis and HIV — Proportion of MSM* Attending STD Clinics† with Primary and Secondary Syphilis Co-infected with HIV by Jurisdiction, STD Surveillance Network (SSuN), 2015

* MSM = Gay, bisexual, and other men who have sex with men (collectively referred to as MSM).
† Includes STD clinics that reported data on at least 25 patients with a diagnosis of primary and secondary syphilis in 2015.
Proportion of MSM* Attending STD Clinics with Primary and Secondary Syphilis, Gonorrhea (GC) or Chlamydia (CT) by HIV Status†, STD Surveillance Network (SSuN), 2015

* MSM = Gay, bisexual, and other men who have sex with men (collectively referred to as MSM).
† Excludes all persons for whom there was no laboratory documentation or self-report of HIV status.
‡ GC urethral and CT urethral include results from both urethral and urine specimens.
Incident Gonorrhea Cases Among GBMSM

Figure 3. Estimated Rate of Reported Gonorrhea Cases by GBMSM, MSW and Women, SSuN, 2010 – 2013*.

* Data shown with 95% Wald Confidence Intervals (CI).

Mark R. Stenger, Heidi Bauer, Elizabeth Torrone, the SSuN Study Group
Need for Better Data

• It is difficult to fully characterize the health needs of the population(s)
• Difficult to identify a patient who is LGBT in need of certain preventive services presenting in care
• Need to collect of sexual orientation and gender identity information on patients
• Need to include SOGI on national surveys and in disease surveillance
Current efforts

• Current federal efforts stress the need to make LGBT people visible through routine data collection of SOGI and to provide culturally sensitive, high quality preventive services and care.
PROGRAM ASSISTANCE LETTER

DATE: February 1, 2016

TO: Health Centers
    Primary Care Associations
    Primary Care Offices
    National Cooperative Agreements

DOCUMENT NUMBER: PAL 2016-01
DOCUMENT TITLE: Proposed Uniform Data System Changes for Calendar Year 2016

I. BACKGROUND

This Program Assistance Letter (PAL) provides an overview of proposed changes to the Health Resources and Services Administration’s (HRSA) calendar year (CY) 2016 Uniform Data System (UDS) to be reported by Health Center Program grantees and look-alikes in February 2017. Additional details regarding these changes will be provided in the forthcoming 2016 UDS Manual.

II. PROPOSED CHANGES FOR CY 2016 UDS REPORTING

A. SEXUAL ORIENTATION AND GENDER IDENTITY (SO/GI) – TABLES 3A, 3B

   Sexual orientation and gender identity are reported on Table 3A, 3B.
A. **Sexual Orientation and Gender Identity (SO/GI) – Tables 3A, 3B**

Sexual orientation and gender identity are reported on Table 3A, 3B.

Rationale: Improving the health of the Nation’s underserved communities and vulnerable populations by assuring access to comprehensive, culturally competent, quality primary health care services is a priority of the Health Center Program. Sexual orientation and gender identity can play a significant role in determining health outcomes. Gaining a better understanding of populations served by health centers, including sexual orientation and gender identity, promotes culturally competent care delivery and contributes to reducing health disparities overall. In addition, adopting sexual orientation and gender identity (SO/GI) data collection in the UDS aligns with the 2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and the Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program. Alignment of UDS SOGI data elements with ONC certification criteria also reduces overall health center reporting burden.
Partners:
Transforming Primary Care for LGBT People

NACHC
• National Stakeholders

Weitzman Institute
• ECHO Technology

Fenway Institute
• LGBT Clinical Expertise
Transforming Primary Care for LGBT People: Project Aim

To improve health outcomes for LGBT patients served by health centers by increasing the availability of culturally responsible comprehensive primary care.
Transforming Care for LGBT People

CDC, NACHC, Weitzman Institute, Fenway Institute
- 40+ ECHO participants
- 10 Breakthrough Series Collaborative sites
- Collection of sexual orientation and gender identity (SOGI)
- Sexual history/risk assessments

We hope to learn
- Models for collecting SOGI and sexual risk
- Facilitators/barriers to providing HIV/STD services to at-risk MSM, transgender women
- Can ECHO be used to improve population health services
**Track A: ECHO Only**
Participants Attend ECHO Sessions
Improved knowledge, beliefs and self-efficacy LGBT Care
Awareness of best practices and learning community

**Intermediate Outcomes:**
- Increased identification of at risk patients, partners, & protective practices from STDs and HIV
- Improved delivery of comprehensive primary care services

**Track B: ECHO plus Practice Improvement**
ECHO Sessions plus Coaching on QI Methodologies and Reporting
Improved knowledge, application of QI methods, pre-post evaluative clinical measures
Application of knowledge as evidenced by comprehensive Primary Care with routine capture of SOGI, Risk-based sexual health histories

**Long Term Outcomes:**
- Decreased transmission, morbidity, and mortality of HIV, STDs for LGBT populations
- Reduced health disparity and enhanced primary care system with public health partnerships

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**INPUTS**

**ACTIVITIES**

**OUTPUTS**

**SHORT-TERM OUTCOMES**

**EXTENDED OUTCOMES**

10/19/2016

TRANSFORMING PRIMARY CARE FOR LGBT PEOPLE BY PROMOTING CULTURALLY APPROPRIATE HEALTHCARE
1. TRACK A: LGBT Project ECHO®
   - Health Center LGBT Provider Champion.
   - Biweekly sessions including didactic and case study components.
   - Apply lessons learned to ensure comprehensive, culturally responsible, evidence-based clinical care for LGBT patients served at the health center.
1. TRACK B: Health Center LGBT Practice Transformation Team - 10 sites
   • Cross-functional team of 4-5 members participates in year-long improvement collaborative--mix of provider champion, care team members, QI, IT.
   • Meets weekly.
   • Tests and implements improvements toward a systems approach to culturally responsible care for LGBT patients.
   • Team leader attends monthly all-team learning calls and quarterly virtual learning opportunities.
Voices from the Field

Sexual Orientation and Gender Identity
• Many of our Spanish speaking patients are leaving the sexual orientation question blank, or entering their sex in the "other" option. We have had our language checked by a local language institute, as well as multiple native speakers, some members of the community and some not. All feel the terms we are using are fine.

Sexual Risk Assessment
• Are we able to modify sexual risk assessment questions? I’d like it know if we are able to ask about "casual" rather than "anonymous" partners?

Risk-Based Screening
• Our local hospital lab doesn’t offer NAAT testing as part of its portfolio. We are now working with the local health department to resolve this issue.

Transgender Patient Care
• Our team met yesterday and we have found that people in our area are asking for hormone therapy, but we have no infrastructure or training to allow us to provide the service. We need a road map!

10/19/2016
Project ECHO LGBT : Faculty

Core team of 6 with visiting faculty to address specific topics

Multidisciplinary team with expertise including but not limited to:
• Family Medicine
• LGBT health
• Infectious Disease
• HIV prevention and care
• Psychiatry
• Behavioral Health
Project ECHO LGBT: The Process

Day Prior to Webinar:
- 2-4 cases sent by ECHO participants to core faculty.
- Faculty reviews cases to offer feedback, guidance, and resources.

Day of Webinar:
- Specific Topic Presentation: didactic presentation by ECHO core faculty or guest faculty member, followed by a Q&A.
- Case Discussion: 5 minute case presentation, followed by consultation Q&A.
- Brief synopsis of case review feedback provided by faculty lead.
Project ECHO LGBT: Learning

- Topics that have arisen frequently include:
  1. Challenges pertaining to integration of behavioral health and primary care;
  2. Exploring gender identity in the context of co-occurring mental illness;
  3. Dosing of gender-affirming hormone therapy in the setting of co-occurring medical problems;
  4. Impact of LGBT stigma (or specifically transphobia) on health.

- Participants appreciate learning about how to affirm their patient's gender identity feeling more confident and competent in working with LGBT patients.
Health Center LGBT Practice Transformation
Learning Collaborative Sites

Transforming Primary Care for LGBT People

- Adelante Healthcare (AZ)
- ChapCare (CA)
- Community Health Center Inc (CT)
- El Rio Community Health Center, AZ
- Family First Health, PA
- Health Delivery, Inc. (MI)
- Metro Community Provider Network (CO)
- NO/AIDS Task Force dba CrescentCare (LA)
- Piedmont Health Services (NC)
- Project Vida (TX)
Transforming Primary Care for LGBT People

Essential Collaborative Materials

This section contains materials you will want to access to inform your work in the Collaborative. The materials include CDC Guidelines and other essential information.

- Essential Collaborative Materials
- Collaborative Zoom Meetings

This file contains the information including the video link to each of the Zoom Meetings related to Collaborative activities.
Purpose of Measures:

**Phase 1**
- Core Measures:
- 5 SOGI-based measures that will be reported monthly by all Improvement Teams participating in the project.

**Phase 2**
- Later Phase Core Measures:
- Risk-based measures among MSM and Transgender Females.

**Phase 3**
- Considerations:
- Offering PrEP to patients who are diagnosed with rectal gonorrhea, providing more frequent STD screenings for high-risk patients, ensuring that partners of patients with treated STDs are tested.

**Pre-Post Measures:**
A detailed set of measures that will be collected pre- and post-participation to assess the impact of the project on key populations of focus.

10/19/2016
Phase 1
Core Measure #1

Number (#) and percent (%) of all patients ≥ 13 years from the participating PCP’s panel seen in the past year who have SOGI documented in the EMR.

**Denominator =**
All unique patients seen in the past year.

**Numerator =**
All unique patients seen in the past year who *answered SOGI screening questions (as defined by HRSA).*
## Core Measure 1
### Preliminary Data from 8 Sites

<table>
<thead>
<tr>
<th></th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number (%) of patients with Sexual Orientation and Gender Identity documented</td>
<td>3407 (5.2%)</td>
<td>4823 (6.8%)</td>
<td>6181 (8.8%)</td>
<td>6891 (9.6%)</td>
<td>7005 (11.0%)</td>
</tr>
<tr>
<td>Number of patients age 13+ with a medical visit in the past 12 months</td>
<td>65,432</td>
<td>70,483</td>
<td>70,619</td>
<td>71,610</td>
<td>71,937</td>
</tr>
</tbody>
</table>
Phase 1
Core Measure #2:

Number and percent of all LGBT patients seen in the past year who received a comprehensive sexual history with risk assessment.

**Denominator =**
All LGBT patients seen in the last year.

**Numerator =**
All LGBT patients seen in the past year who received a comprehensive sexual history with risk assessment.
## Core Measure 2
Preliminary Data from 8 Sites

<table>
<thead>
<tr>
<th></th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number (%) of patients with a</td>
<td>41</td>
<td>59</td>
<td>64</td>
<td>75</td>
<td>117</td>
</tr>
<tr>
<td>risk-based sexual history</td>
<td>(32.8%)</td>
<td>(36.2%)</td>
<td>(32.0%)</td>
<td>(40.5%)</td>
<td>(50.9%)</td>
</tr>
<tr>
<td>documented</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of LGBT patients age</td>
<td>125</td>
<td>163</td>
<td>200</td>
<td>185</td>
<td>230</td>
</tr>
<tr>
<td>13+ with a medical visit in the</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>past 12 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Phase 1

Core Measure #3:

Number and percent of all LGBT patients seen in the past year who were tested for syphilis.

Denominator =
All LGBT patients seen in the last year.

Numerator =
All LGBT patients seen in the past year with a documented syphilis serology.
Core Measure 3
Preliminary Data from 8 Sites

<table>
<thead>
<tr>
<th></th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number (%) of patients tested for syphilis</td>
<td>968 (75.6%)</td>
<td>1008 (72.9%)</td>
<td>1063 (71.2%)</td>
<td>1129 (72.1%)</td>
<td>1175 (71.0%)</td>
</tr>
<tr>
<td>Number of LGBT patients age 13+ with a medical visit in the past 12 months</td>
<td>1281</td>
<td>1383</td>
<td>1494</td>
<td>1566</td>
<td>1656</td>
</tr>
</tbody>
</table>
Phase 1

Core Measure #4:

Number and percent of all LGBT patients seen in the past year who were tested for chlamydia / gonorrhea.

**Denominator =**

All LGBT patients seen in the last year.

**Numerator =**

All LGBT patients seen in the past year with a documented lab result for chlamydia / gonorrhea.
## Core Measure 4
### Preliminary Data from 8 Sites

<table>
<thead>
<tr>
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<th>March</th>
<th>April</th>
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<th>June</th>
<th>July</th>
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</thead>
<tbody>
<tr>
<td><strong>Number (% of patients tested for</strong></td>
<td>999 (78.0%)</td>
<td>1077 (77.9%)</td>
<td>1158 (77.5%)</td>
<td>1237 (79.0%)</td>
<td>1466 (88.5%)</td>
</tr>
<tr>
<td><strong>chlamydia/gonorrhea</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Number of LGBT patients age 13+ with a</strong></td>
<td>1281</td>
<td>1383</td>
<td>1494</td>
<td>1566</td>
<td>1656</td>
</tr>
<tr>
<td><strong>medical visit in the past 12 months</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Phase 1
Core Measure #5:

Number and percent of all HIV-negative LGBT patients seen in the past year who were tested for HIV.

**Denominator** =
All HIV-negative LGBT patients seen in the past year.

**Numerator** =
All HIV-negative LGBT patients seen in the past year who **have an HIV test result documented**.
### Core Measure 5
#### Preliminary Data from 8 Sites

<table>
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<tr>
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<th>March</th>
<th>April</th>
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<th>June</th>
<th>July</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number (%) of patients tested for HIV</td>
<td>205 (47.6%)</td>
<td>243 (47.6%)</td>
<td>282 (47.0%)</td>
<td>276 (45.8%)</td>
<td>326 (43.4%)</td>
</tr>
<tr>
<td>No of HIV negative (or unknown HIV status) LGBT patients age 13+ with a medical visit</td>
<td>431</td>
<td>511</td>
<td>600</td>
<td>603</td>
<td>751</td>
</tr>
</tbody>
</table>
Implementing Sexual Orientation and Gender Identity (SO/GI) Data: Learnings from “Transforming Primary Care for LGBT People”

Workflow Considerations: Where to Collect the Data

Electronic health record modifications

• “No one person understands everything about the EMR, so no one person can make the changes needed to capture SO/GI. It takes a multi-disciplined approach.”

• “It is proving more difficult than anticipated to understand “where the data go” between the registration and medical chart sides of our EMR. Data on one side cannot pass to the other, and that has a great impact on the completeness of this work…May have to approach leadership with cost+ requests for system changes.”
Implementing Sexual Orientation and Gender Identity (SO/GI) Data: Learnings from “Transforming Primary Care for LGBT People”

Workflow Considerations: Where to Collect the Data

Collecting data at registration versus collecting in the exam room

- “Asking in the exam room ensures the information gets into the clinical record for provider use; eliminates non-clinical staff or other patients learning SO/GI status.”
- “Asking at registration as part of UDS annual verification helps to standardize.”
Implementing Sexual Orientation and Gender Identity (SO/GI) Data: Learnings from “Transforming Primary Care for LGBT People”

Workflow Considerations: Using the Information Provided by the Data

Sexual Orientation data versus Gender Identity data

• “We had a lot of staff who thought very strongly that sexual orientation was not best asked in the front whereas gender identity, which you need to know right away so that you can get the pronouns right and get their registration right, did sit in the front. They're obviously two different questions.”
Workflow Considerations: Who Provides the Data and Who Collects the Data

Patient engagement and modifications based on population served

- “There is a generational difference in translations. Older Spanish-speaking patients are more likely to confuse gender and sexual orientation.”
- “Patients have complained at all sites of the collection of SO/GI data (feel offended, cultural issue and additional paper work to complete.)”
- “Patients [at our site] report appeal of having SO/GI data collected in the exam room.”
- “Adolescent LGBT patients may not disclose SO/GI if parent is in the exam room,” and “parents may not accurately report adolescent patient SO/GI on UDS forms.”
Workflow Considerations: Who Provides the Data and Who Collects the Data

Staff buy-in, engagement, and roles

• “All staff and providers at [our clinic] had a training using Kaiser “Out” video. This triggered some really good questions and conversations, especially by the frontline staff, who reported feeling like this was the first chance they had been given to talk about this population.”

• “Leadership presenting the rationale for focusing on LGBT health at an organization-wide annual meeting can support goals of inclusion, SO/GI data collection.”

• Staff felt supported by creation of “an elevator speech regarding the new process for collecting SO/GI from patients in addition to a written rationale.”
Implementing Sexual Orientation and Gender Identity (SO/GI) Data: Learnings from “Transforming Primary Care for LGBT People”

Workflow Considerations: Using the Information Provided by the Data

Providing Care based on Patient Responses

- “Providers are given extensive training on sexual risk based assessment to try to ease discomfort with using clinical words related to the assessment.”
- “It is useful to have a reference guide that details the appropriate types of STI screening and testing for specific demographics.”
Implementing Sexual Orientation and Gender Identity (SO/GI) Data: Learnings from “Transforming Primary Care for LGBT People”

Workflow Considerations: Using the Information Provided by the Data

Medical-Legal Partnerships

- Support “drafting gender-affirming guidelines to delineate protocols for using patients’ lived names and pronouns, restroom access and expectations in the event of a workplace gender transition.”
- “Collaborating with community partners to implement name change assistance pilot program” for trans* patients.
Summary

- Changes in the US health care system and new technologies have created new opportunities to improve individual patient care and population-level health.

- Collaboration between public health and primary care can help identify and maximize the resources available in a community (e.g., financial, technological, human, etc), and ultimately be a vehicle for addressing complex individual- and community-level health issues that may otherwise be out of reach.
LGBT populations are disproportionately burdened by HIV and STDs and other health issues, but lack of data make it difficult to fully characterize their needs.

Without SOGI demographic data, a clinician may not recognize an LGBT patient presenting in care who might benefit from certain preventive services.

Current federal efforts stress the need to make LGBT people visible through routine data collection of SOGI and to provide culturally sensitive, high quality preventive services and care.
Thanks to Collaborators

• CDC
  – Bruce Furness
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  – Harvey Makadon
  – Chris Grosso
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  – Jane Powers
  – Alex Keuroghliian
  – Genna Ayres
  – Kevin Ard
  – Molly McHenry
  – Sixto Munoz
Final Thoughts...
Screening is key!

STD Screening is Critical:
If you are sexually active, be sure to talk to your healthcare provider about STD testing and which tests may be right for you.

Women:
- If you are a sexually active woman younger than 25, or have risk factors such as new or multiple sex partners, you should request annual chlamydia and gonorrhea tests.
- If you are a pregnant woman, you should request syphilis, HIV, chlamydia, and hepatitis B tests early in your pregnancy. If you have new or multiple sex partners, you should also request gonorrhea testing early in pregnancy.

Gay and bisexual men:
- If you are a sexually active man who is gay, bisexual, or has sex with men, you should request tests for syphilis, chlamydia, gonorrhea, and HIV at least once a year. More frequent STD testing is recommended for men at high risk.

Sources:
STD Treatment Guidelines On The Go:
The STD Tx Guide App

- Gives clinicians easy access to CDC’s current STD Treatment Guidelines
- Available for mobile phones and tablets
- Includes STD diagnostic and treatment information and “A Guide to Taking a Sexual History”
- FREE!
Thank you!

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For more information please contact Centers for Disease Control and Prevention

1600 Clifton Road NE, Atlanta, GA 30333
Telephone: 1-800-CDC-INFO (232-4636)/TTY: 1-888-232-6348
E-mail: cdcinfo@cdc.gov Web: http://www.cdc.gov

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.