

Chapter 2

Comprehensive Primary Health Care for HIV Positive Gay Men

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The Comprehensive Primary Health Care Approach

The concept of primary health care (PHC), as largely practiced within the context of the United States (USA), is understood as a person's first contact with the health care system, which is expected to be nonhospital-based preventative clinical services provided by physicians, nurse practitioners, and physician assistants (Stoeckle, 2009). Research advances in primary health care medicine and the development of evidence-based practice guidelines have provided a robust set of clinical tools to address physiological and psychological needs of patients that prevent severe acute illness events that result in lengthy, expensive, and avoidable hospital admissions (Aberg et al., 2009). Nonetheless, the concept and practice of primary health care does not sufficiently accommodate the complexity of life experiences that impact the health of individuals in the community, including gay-identified men who are living with Human Immunodeficiency Virus (HIV). The disease/illness management focus of the United States' version of primary health care has led health experts to call for it to be more precisely labeled "selective primary health care" (Cueto, 2004; Magnussen, Ehiri, & Jolly, 2004). By contrast, the comprehensive primary health care approach is one that attends to the social, cultural, and political realities of individuals and is well suited as an approach to care for HIV positive gay men who may be experiencing a multitude of social oppressions that impact their health.

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Comprehensive primary health care is a concept that was commissioned by leaders in global health policy and clinical practice who understood that population advances in health could not be achieved without addressing social determinants of health and the inequitable social processes that led to disproportionately poor health outcomes in some groups compared to others (Lynam & Crowley, 2007). This is articulated in the Declaration of Alma Ata—adopted by the World Health Organization in 1978—a policy statement that advanced a holistic definition of health that included social and economic wellness and proposed structural level intervention strategies necessary to achieve “health” for all (International Conference on Primary Health Care, 1978). Initially trumpeted as a solution for resource-limited countries, the comprehensive PHC approach has also been embraced by advanced capitalist societies such as France, Brazil, and Canada—all of whom have outpaced the USA in the gains made in the prevention and management of HIV infection among gay men (Hutchison, Levesque, Strumpf, & Coyle, 2011; Ricketts, Naiditch, & Bourgueil, 2012). In this chapter, we move beyond the concept of primary care towards a more serious embrace of comprehensive primary health care considerations for HIV positive gay men. Our objective in writing this chapter is for the reader to gain a core understanding of what is *comprehensive primary health care* and its applicability as an approach to clinical practice with gay-identified men living with HIV.

Principles of Comprehensive Primary Health Care

There are five principles in comprehensive primary health care. These principles are interrelated in that each is a necessary component for maximizing the degree to which an individual’s life is not only disease-free (biomedical and selective primary care models), but also lived to its full potential capacity for social and economic wellness (Magnussen et al., 2004). In order for primary health care to be impactful on the health of individuals and communities there must be a sufficient number of qualified health practitioners trained with the requisite skills to appropriately care for them. The principle of (1) *health care provider capacity development* indicates that health care teams should be composed of personnel (e.g., nurses, physicians, social workers) who are prepared to work together to support individuals in the management of their physical and social wellness needs. The second principle, (2) *community participation*, stipulates that individuals and their communities must be involved in decision-making regarding policies and practices that will ultimately structure how they receive health care as well as the nature and volume of care that will be provided. This is envisioned as a collaborative process actively engaged with individuals and/or communities that lead to greater self-determination for their health and overall wellness. Recognizing that some of the life complexities that accompany an HIV diagnosis are outside the scope of what health care practitioners can address, the principle of (3) *intersectoral collaboration* is proposed as the coordinated assemblage of resources and services from an array of sectors that are relevant to the individual being able to achieve an optimal state of health and

wellness. This goes beyond popular notions of interprofessional or interdisciplinary care, which are typically intrasectoral collaborations across areas such as nursing, pharmacy, social work, and psychology.

The comprehensive PHC principle of intersectoral collaboration calls for coordinating with services outside of the health care sector—for example, housing, criminal justice, employment and education sectors—to more wholly address factors that impact on an individual's health. In order to support individual health maintenance and the prevention of, and recovery from, illness events the (4) *appropriate use of technology* principle stipulates that providers should utilize clinical, social, and behavioral innovations that are not only scientifically sound but also culturally congruent and ones that can be sustained within an individual's and/or communities' economic means. Last, the principle of (5) *accessibility and equity* states that services needed to achieve and sustain optimal states of wellness should be universally accessible to all individuals in a society. Underlying the principles of accessibility is the active and deliberate disruption of institutionalized social processes (such as homophobia, racism, patriarchy) that impede an individual's ability to seek and receive the care at the time and in the quantity and quality that it is needed to achieve optimal wellness (Nelson, Walker, DuBois, & Giwa, 2014).

Evidence-Base for Comprehensive Primary Health Care

Social Determinants of Health

The literature on social determinants of health provides a foundation for grounding a discussion regarding comprehensive primary health care (Baum, 2008; Centers for Disease Control and Prevention, 2010; Rachilis et al., 2016). Research conducted over several years has established that poor health outcomes cluster together with poor social, economic, and political conditions—in particular is the position that marginalization, be it social, cultural, or political (or any combination of the three), negatively impacts the health of those who are the subject of it (Lynam & Crowley, 2007; Navarro & Muntaner, 2004; Nelson et al., 2016). This is particularly the case with HIV infection among many gay men. While there are examples of the mainstreaming of same-gender practices in the USA, gay men remain a socially marginalized group. The marginalization of HIV positive gay men's sexualities is compounded by the intersection of HIV stigma that can occur even within lesbian, gay, bisexual, and transgender communities (Smit et al., 2012). Homophobia, heteronormativity, racism, and HIV/AIDS stigma are all social processes that impact various subcommunities of HIV positive gay men and that comprehensive primary health care approaches can help to mitigate (Courtenay-Quirk, Wolitski, Parsons, & Gomez, 2006; Malebranche & Nelson, 2013; Nelson et al., 2014, 2016).

As mentioned earlier, the comprehensive primary health care approach moves beyond the biomedical management of illness but includes attention to factors that

impact the overall health and well-being of HIV positive gay men. The use of comprehensive primary health care as a public health system strategy for the effective management of HIV among gay men has increased in health systems globally. Communities around the world have made great strides in delaying progression to AIDS and reducing HIV/AIDS mortality among gay men and other men who have sex with other men (Berkman, Garcia, Munoz-Laboy, Paiva, & Parker, 2005; Beyrer et al., 2011; Flowers & Davis, 2012; Galvão, 2005; Helleberg et al., 2012; Parker, 2009; van Griensven & van Wijngaarden, 2010). This is partly accomplished through addressing inequitable social processes and implementing anti-oppression strategies that facilitate engagement in medical care, and ensure equitable access to medical attention (Nelson et al., 2014; Seffner, Garcia, Muñoz-Laboy, & Parker, 2011).

Social Inequities and HIV Outcomes

A number of studies have been conducted that indicate the poor HIV outcomes are not evenly distributed across the entire population of people living with HIV. This is important because HIV positive gay men cross a multitude of socioeconomic spectra. Homophobia and HIV stigma are two important indicators of HIV outcomes (Garcia et al., 2016; Mayer, Bekker, et al., 2012). A study examining the relationship among stigma, medication adherence self-efficacy, and HIV outcomes among 202 HIV positive patients found that HIV stigma mediated the relationship between self-efficacy and quality of life (Li et al., 2011). These results are consistent with other HIV research on stigma and social marginalization (Kinsler, Wong, Sayles, Davis, & Cunningham, 2007; Mahajan et al., 2008; Nelson et al., 2016; Vanable, Carey, Blair, & Littlewood, 2006), indicating that anti-stigma and anti-oppression clinic environments optimize wellness outcomes among HIV positive gay men. Nonetheless, HIV/AIDS stigma and other oppressions are not limited to the clinic environment. Even in the communities where they live and socialize, the degree to which HIV positive gay men experience other societal marginalization will impact on their overall quality of life including their experiences of wellness, and vulnerabilities to illness and death (Cole & Omari, 2003; Courtenay-Quirk et al., 2006).

Inequitable Distribution in HIV Care

There have been considerable advancements with the advent of HIV antiretroviral therapies. Unfortunately, these gains are not equally distributed across the entire population of HIV positive gay men and are often tempered by the intersection of social inequities that interfere with the ability of marginalized subgroups of HIV positive gay men to optimize self-management of their therapies (Rachilis et al., 2016). The U.S. Health Resources and Services Administration (HRSA) operates

the Ryan White HIV/AIDS Comprehensive AIDS Resource Emergency (CARE) program that covers health care costs for people living with HIV who do not have sufficient income or insurance coverage to pay for HIV-related services (HRSA, 2010). The program has been in existence since 1990 and serves nearly 900,000 people per year (HRSA, 2010). Even with the additional HIV care capacity created by the Ryan White HIV/AIDS CARE program, inequities exist among gay men and other MSM with regard to enrollment and maintenance in HIV care (Young et al., 2016).

In a 7-city study of 610 marginalized (e.g., substance using, mental illness history, incarceration history) HIV positive people, researchers found that the uninsured, homeless, and those without access to mental health care had less access to HIV primary medical care (Cunningham et al., 2007). Results also showed that these groups were more likely to receive their HIV care in emergency situations. These and other disparities in access to HIV care have been documented in the literature for nearly two decades (Shapiro et al., 1999). Similar inequities exist with regard to young HIV positive gay males. Compared to MSM who acquire HIV infection in adulthood, MSM who sexually acquire HIV during their youth have lower rates of retention in HIV care. Numerous studies indicate that the major challenge for HIV positive adolescents is the risk of being lost-to-care between transitions from pediatric to adult care (Agwu et al., 2012; Chandwani et al., 2012; Dowshen & D'Angelo, 2011; Hussen, Chahroudi, et al., 2015). For example, in a retrospective study of 287 HIV positive youth (age 12–24) enrolled in multisite ($n = 18$) HIV treatment trials aimed at linking them to pediatric HIV/AIDS care between 2002 and 2008, Agwu et al. (2012) found that while two-thirds of youth initiated HAART, one-third of those transferred to adult care discontinued HAART. Researchers in this study also found that 50% of those who discontinued HAART on transition to adult clinical site were not virally suppressed. Further, the only independent predictor of HAART discontinuation identified in their regression analysis was transition to adult HIV care (adjusted hazard ratio: 1.23; 95% CI: 0.80–1.87) (Agwu et al., 2012). This phenomenon disproportionately affects MSM since they represent the majority of adolescent and pediatric cases of HIV (Centers for Disease Control and Prevention, 2015). Progression to AIDS and decreased access to quality HIV primary medical care are also more likely to occur within predominantly poor urban communities than in middle and upper class communities (Heslin, Andersen, Ettner, & Cunningham, 2005; Losina et al., 2009; Miles et al., 2013; Moore, 2011).

Inequities in HIV Outcomes and Care Quality Indicators

Advances in HIV antiretroviral therapy has helped to extend the lifespan of people living with HIV. Health science has developed more sophisticated models for treating HIV as well as managing the patients experience of treatment by such mechanisms as combination formulations which reduce the number of pills that must be taken at once and also formulations that allow for once daily dosing which makes

self-management of HIV antiretroviral therapy drugs more manageable for many HIV positive gay men. Health services research in the areas of patient HIV outcomes also provides evidence of unequal distribution in the quality of HIV care and its associated outcomes (Hall, Byers, Ling, & Espinoza, 2007; Karach, Hall, Tang, Hu, & Mermin, 2015; Laffon et al., 2015; Simard, Fransua, Naishadham, & Jemal, 2012).

For example, a large population study of HIV positive gay- and non-gay-identified MSM was conducted using epidemiologic data from 33 US states on HIV/AIDS cases between 1996 and 2004 to examine inequities in HIV prevalence and progression to AIDS (Hall et al., 2007). Researchers found that, compared to White (25%) MSM, higher percentages of Blacks (33%) and Latino (32%) MSM progressed to AIDS within 3 years of their initial HIV diagnosis (Hall et al., 2007). The researchers also found among the 62,045 MSM with AIDS during 1996–2002, a significantly higher percentage of non-Hispanic Blacks (34%) had severely weakened immune systems (<50 CD4 cells/ μ L) at the time of their AIDS diagnosis than did Hispanics (28%) and non-Hispanic Whites (24%). Furthermore, non-Hispanic Black MSM were significantly more likely than non-Hispanic Whites or Hispanics to have died within 3 years of receiving an AIDS diagnosis (Hall et al., 2007). This specific analysis of Black MSM is important since stress, including the stress of everyday experiences of racism, is known to negatively impact on HIV outcomes such as viral load and CD4 T-cell count (Lesserman, 2008; Oramasionwu et al., 2009).

Reducing disparities in HIV outcomes require more comprehensive approach than that offered by biomedical science and practice alone (Mayer, Bekker, et al., 2012). An interdisciplinary approach to care that more fully accommodates the complexities of the lives of HIV positive gay men is needed in order to regain momentum in the reduction of new infections and increased quality of life. Here, we will specifically outline strategies within a comprehensive primary health care approach for HIV positive gay men—focusing on the five guiding principles of PHC and the ways in which they can be operationalized at the clinical encounter level as well as clinic/institutional policy level.

Applying the Comprehensive Primary Health Care Approach: Health Care Provider Capacity Development

Demonstration of HIV Clinical Excellence

As research in HIV nursing, medicine, and pharmacotherapeutics yield more clinical tools with which to support optimal physiological functioning of HIV positive gay men, health care practitioners will need to be current with regard to how to utilize these advances in the context of the patients' life situations. A number of organizations provide discipline specific continuing education offerings that allow practitioners to attain advanced levels of clinical training in HIV care. The American Academy of HIV Medicine (AAHIV) provides board certification for physicians, nurse practitioners, physician assistants, and pharmacists. Health care providers

who attain this certification have an advanced level of clinical expertise as assessed by their practice experience and a national certification examination (AAHIV, 2013). Registered professional nurses are also able to attain advanced clinical preparation through the HIV/AIDS Nursing Certification Board (HANCB) that offers continuing education to registered nurses leading to the certification as AIDS Care Registered Nurse and Advanced AIDS Care Registered Nurse (HANCB, 2013). The Association of Nurses in AIDS Care (ANAC) and the HIV Medicine Association (HVMA) do not offer certifications, but have published online guidance and links to continuing education resources intended to encourage a high standard of practice for nurses and physicians providing ongoing clinical care to HIV positive gay men and others living with HIV and AIDS (ANAC, 2013; HVMA, 2010). More recently, HRSA announced its intention to invest funding to support the development of graduate education programs aimed at creating nurse practitioner and physician assistant specialists in HIV care (HRSA, 2013). The expansion of the number of health professions graduate programs that train providers to specialize in the care of HIV positive people is consistent with the U.S. National HIV/AIDS Strategy and is a crucial step in building and maintaining a competent HIV health workforce until an effective cure is found.

Multicultural Competencies

Health care practitioners can also improve their level of practice by increasing their capacity to understand patients in the patients' own sociocultural contexts (Nelson et al., 2014). These contexts are multifaceted and include LGBT culture, ethnic culture, and spiritual practice contexts (Hussen, Chahroudi, et al., 2015). Numerous studies indicate that patients rate their clinical experiences more favorably when they perceive that their differences with regard to age, ethnicities, sexualities, and spiritualities are respected and appreciated by their health care providers (Campbell, Ramsay, & Green, 2001; Trevino et al., 2010). Among HIV positive gay men, health care provider cultural competency is also associated with retention in care and self-reported quality of care (Hightow-Weidman, Smith, Valera, Matthews, & Lyons, 2011; Magnus et al., 2010). Opportunities for multicultural competency continuing education exist through HRSA funded AIDS Education & Training Centers (AETCs). The 11 AETCs across the USA routinely offer trainings for practitioners on best practices in providing care to HIV positive gay men and subpopulations (e.g., HIV positive gay men who use illicit substances; HIV positive gay men with mental illness) with unique sociocultural nuances that must be considered when working to develop plans of care (Ciesla & Roberts, 2001; Cunningham et al., 2007; Hatcher, Toldson, Godette, & Richardson, 2009; Shoptaw et al., 2012; Young, Shoptaw, Weiss, Munjas, & Gorbach, 2011; Young et al., 2016). Each AETC is responsible for providing technical assistance and continuing education to specific geographic regions of the country. Information regarding how to participate in continuing education through your regional AETC can be found by visiting their national website at www.aids-ed.org.

Life Stage-Specific Needs

HIV medical care is generally categorized into either pediatric or adult specialty practices. These life stage-specific HIV specialties are important given that there are a host of generational needs that must be attended to involving the physiology, psychology, and social context of HIV positive gay male youth compared to HIV positive adult gay men (Gayles, Kuhns, Kwon, Mustanski, & Garofalo, 2016; Hussen, Harper et al., 2015). Continued attention must be given to addressing the needs of these age groups. Nonetheless, tremendous opportunities remain for health care providers to expand their capacity to address the needs of subpopulations that are often subsumed—and many times made invisible—within the pediatric and adult HIV specialty categories (Young et al., 2016). Here, we will discuss the importance of HIV providers to develop capacities to serve adolescent (pediatric) and older adult (adult) HIV positive gay men.

Adolescents

Based on current national surveillance data, youth ages 20–24 had the highest age-specific number of new HIV infections in the United States (Centers for Disease Control and Prevention, 2015). This age group is considered to be “adolescence” since it is the time of life in which the brain has matured to a point that one has accomplished all the major pediatric developmental milestones but has not yet reached the full stage of adult development (Weinberger, Elvevag, & Giedd, 2005). Adolescents’ specific developmental stage—which is heavily focused on exploration and establishing independence from authority figures—has implications for what are the best strategies to promote retention in HIV medical care, adherence to antiretroviral treatment and preventing onward transmission of HIV (Fielden, Chapman, & Cadell, 2011; Hagan, Shaw, & Duncan, 2008; Leonard, Markham, Bui, Shegog, & Paul, 2010).

There is a growing body of research focused on intervention models that support retention in care and treatment adherence for HIV positive gay adolescent males (Centers for Disease Control and Prevention, 2014; Gayles et al., 2016). Much of this research has yielded evidence regarding specific characteristics that optimize retention of HIV positive adolescent males. These include ensuring that clinic personnel exhibit multicultural competencies in their clinical practice and service delivery (Fortenberry, Martinez, Rudy, & Monte, 2012; Gilliam et al., 2011; Magnus et al., 2010) and that adolescents are provided with coordinated services to address some of their complex psychosocial needs (Bird, LaSaa, Hidalgo, Kuhns, & Garofalo, 2016; Birnbaum, Loundsbury, Eastwood, Palma, & Jo, 2013; Fortenberry et al., 2012; Magnus et al., 2010). Other researchers are conducting research on interventions that take advantage of new technologies and capitalize on their popularity as communication mechanisms to promote treatment adherence (Hirshfield et al., 2016; Shegog, Markham, Leonard, Bul, & Paul, 2012). For example, Shegog et al. (2012) developed and tested a web-based ARV adherence support application for HIV pos-

itive adolescents and found that the intervention program was associated with increased adherence self-efficacy ($p < 0.05$) and increased understanding of the importance of maintaining a regular daily dosage schedule ($p < 0.01$). The utilization of technologies that are most compatible with the communication modes used among HIV positive gay adolescent males is a strategy that is consistent with comprehensive PHC's "*appropriate technology*" principle.

Older Adults

For older adult men, the experience of living with HIV can be complicated by declines in the expansiveness in their social networks or intersecting perceptions of decreased social significance within a LGBT community-context that has historically placed high value on the norms of youth and youthful body images (Groves, Golub, Parsons, Brennan, & Karplak, 2010; Halkitis et al., 2012; Heckman et al., 2002; Lyons, Pitts, Grierson, Thorpe, & Powell, 2010). There is significant research indicating that many HIV positive adult gay men experience depression related to experiences of loneliness, rejection, and HIV-related stigma (Groves et al., 2010). Decreases in perceived sexual desirability may create a situation where older adult HIV positive men are uncomfortable disclosing their HIV status due to the threat of rejection—that may be compounded by the ongoing (even if latent) perceived threat of rejection due to their age (Halkitis, Kapadia, Ompad, & Perez-Figueroa, 2015; Sankar, Nevedal, Neufeld, Berry, & Luborsky, 2011; van Kesteren, Hospers, van Empelen, van Breukelen, & Kok, 2007). A number of interventions have been developed to support interpersonal communication skills development among HIV positive gay men (Eaton, West, Kenny, & Kalichman, 2009; Kalichman et al., 2001). One well-known intervention is Healthy Relationships, an evidence-based group intervention program that promotes self-efficacy and relational skills development for people living with HIV (Kalichman et al., 2001; Kalichman, Rompa, & Cage, 2005). Based on social cognitive theory (Bandura, 1985), Healthy Relationships has a strong emphasis on skill development by having intervention participants first observe and then practice the target behaviors, attitudes, or expectations being modeled (Kalichman et al., 2001, 2005). Other interventions focus specifically on supporting men's decision-making skills regarding the disclosure of their HIV status in various situations (Serovich, Reed, Grafsky, & Andrist, 2009; Serovich, Reed, Grafsky, Hartwell, & Andrist, 2011). These complex life stage-specific needs require serious attention by providers working to increase their capacity to deliver quality care to HIV positive men—young and old alike.

Accessibility and Equity

With decreased access to care and mounting societal discrimination, HIV positive gay men require care that establishes access and longitudinal medical management. Treatment will be most effective only when access to care has been well

established. In order to provide comprehensive primary health care for HIV positive gay men, it is not only necessary to provide a supportive care environment, but also necessary to implement a deliberate anti-racism, anti-oppression framework for practice (Mullaly, 2010; Nelson et al., 2016; Yee, 2005). Due to White supremacy, racism, heteronormativity, and homophobia, White and heterosexual men are granted explicit and implicit social privileges when compared with those who are non-white and/or self-identify as gay (Nelson et al., 2014). Practice frameworks can begin by attending to specific language that supports underlying hegemonic inequities that disenfranchise HIV positive gay men. For example, barriers to access for HIV positive gay men can come in forms as simple as the advertising of your clinic or community-based program. A deliberate anti-oppressive framework requires that health programs do more than “not discriminate” but specifically advertise that their services are inclusive of HIV positive gay men. Additionally, ensuring that program services are advertised at businesses and events that historically target and attract gay men demonstrates a willingness to be visibly associated with gay-identified activities—which is an important anti-oppression strategy (Nelson et al., 2014).

Another area where anti-oppressive practice can be exercised is in the interpersonal communication between the client and the providers. The manner in which health histories, risk assessments, and other clinical data are collected can be experienced as oppressive. For example, if an HIV positive gay man discloses that he has performed anal insertive sex with multiple partners in the past 3 months, an inquiry to him of: “Please, tell me about what motivated your sexual practices with these various partners” is consistent with anti-oppressive practice versus asking for the man to “please tell me the reasons why you were promiscuous and put other peoples lives at risk.” If the patient is exhibiting signs of anxiety or distress, the practitioner may even wish to verbally acknowledge the psycho-emotional difficulties that the patient may be experiencing. In this way, the practitioner does not necessarily normalize the behavior, but makes an inquiry that avoids a moral evaluation of the behavior and reduces the risk of creating an interpersonal environment where the patient may not feel comfortable to further disclose or discuss his needs and concerns. Adopting some of these practices and identifying and incorporating other anti-oppressive practices can help generate environments where comprehensive primary health care can be more equitably accessed.

Community Participation

Health Program Integration

Including HIV positive gay men in the implementation of health programs are common mechanisms by which both clinic and community-based HIV/AIDS service programs achieve their goals for community participation. Health program integration benefits organizations by having individuals, who live the experience of being

a gay man diagnosed with HIV, to help deliver services to others in this population. In addition to integrating HIV positive gay men into health programs, consumer advisory boards are sometimes utilized for generating feedback on how to improve organizational practices on working with HIV positive gay men. The consumer advisory boards can also be useful in identifying emerging social, cultural, and health trends among HIV positive gay men that may stimulate the development of new programs or treatment strategies. Consumer advisory boards are also helpful in ensuring that the clinics and programs are maximally responsive to the interests of HIV positive gay men. This can include interests related to clinic policies that affect the men. For example, a clinic that is contemplating a change in policy that reduces the number of wellness visits that are booked within a 12-month period, for patients who pay a reduced sliding scale fee for clinic services, should include full input from HIV positive gay men since such a decision will impact the care that the men can expect to receive. Consumer advisory boards could also provide input on research targeting HIV positive gay men with the aim of ensuring that the studies are as fair, relevant, and beneficial as possible to the men who will enroll. Health program integration can be achieved in numerous ways. Whichever methods are chosen, token participation should be avoided and full, serious input into program design and implementation must be the goal.

Developing a Client-Centered Treatment Plan

There is increasing attention given to the benefits of developing treatment plans that are centered on the client's sociocultural context and other situational factors that may be occurring at the time of the plan development. Numerous studies indicate that client-centered treatment plans are associated with greater treatment plan adherence by patients (Bogart et al., 2012; Church & Simon, 2010; Farris & Dietz, 2013; Gilman, Hidalgo, Thomas, Au, & Hargreaves, 2012). Moreover, health care providers have a moral imperative to ensure that the treatment plans for patients are based on what the patients' believe are in their own best interest (Beauchamp & Childress, 2001). HIV positive gay men who are fully informed about treatment options may decide to exercise options that the treating physician or nurse practitioner may not agree is the best course of action. It is important that the provider's understanding of the clinical situation is reconciled with the patient's understanding of what is the plan that they want for themselves. Nonetheless, it remains that the interests of the health care provider must not be prioritized over the self-expressed interests of the patient—regardless of the outcome implications. Major professional medical organizations have published statements that are consistent with the notion that treatment plans and approaches must be centered on the self-expressed interests of the patients (American Board of Internal Medicine Foundation, American College of Physicians American Society of Internal Medicine Foundation, & European Federation of Internal Medicine, 2002). Additionally, there is an abundance of evidence-based interventions for assisting providers to improve communications

with patients such that the patients' needs and wishes are more likely to result in a plan of care that reflects the patients' interests (Harrington, Noble, & Newman, 2004; Kaymeg, Howard, Clochesy Mitchell, & Suresky, 2010; Rao, Anderson, Inui, & Frankel, 2007; Tennstedt, 2000). Providers can use these and other interventions to better enhance their skills in listening to HIV positive gay men's needs and incorporating them accordingly into their plans of care.

Intersectoral Collaboration

Health and Social Service Sectors

Collaboration between disciplines within health care is necessary to effectively promote physical and social wellness for HIV positive gay male patients. For example, the primary physician, nurse practitioner, or physician assistant should, whenever indicated, work in conjunction with other health providers such as pharmacists, psychologists, social workers, and registered dietitians. Notwithstanding the importance of multidisciplinary collaborations within health care, a comprehensive primary health approach stipulates that multidisciplinary efforts across sectors, outside of the health care domain, are required to fully address the complexities of patients' needs. HIV positive gay men with complex needs may require that health care providers coordinate care with a myriad of sectors for such services as job placement, employment skills training, rehabilitation services, housing, and community-reintegration supportive services for ex-offenders. Partnering with these programs can enhance health care providers' abilities to meet the needs of HIV positive gay men by ensuring that other basic needs receive appropriate attention by the appropriate professionals.

Human Rights Sector

Human rights workers engage in advocacy to increase public awareness of social injustices with their aim of reducing the de facto privileges that are withheld from groups that are marginalized and otherwise made less powerful groups, such as gay men, people of color, and people living with HIV (Oldenburg et al., 2016). Human rights workers have a broad scope of practice and have the capacity to provide advocacy for HIV positive gay men on a range of important issues from marriage equality to demanding accountability from insurance companies whose coverage policies discriminate against HIV positive applicants and enrollees (Barclay, Bernstein, & Marshall, 2009). Many immigrants and refugees, especially those from HIV-endemic countries, may arrive to the USA. Many of these individuals may learn of their HIV status only after arriving in the USA. Those who are gay-identified may find that is unsafe to return to their countries of origin either

because of poor HIV/AIDS care infrastructure or because engaging in HIV/AIDS care will lead to imminent disclosure of their sexual behavioral practice, which could increase their vulnerability to violence and other homophobia-based social marginalizations (Nelson et al., 2015). In these cases, human rights workers can support newcomers to the USA in navigating asylum processes and helping them link with legal professionals who specialize in immigration cases. Human rights workers may also help individuals who are undocumented, link to health service networks that practice multicultural competence and that may provide free clinical services without requiring patient's to authenticate their identities with official government documents such as social security cards, birth certificates, or drivers licenses. Such strategies may reduce fears that engagement in health care systems place them at high-risk for apprehension by police agents and deportation.

Appropriate use of Technology

Advances in ART

Antiretroviral therapy (ART) is the cornerstone of pharmacologic management of HIV. The goals of ART include CD4 count increase, decreased HIV viral load, and delayed progression to AIDS. Studies indicate that early initiation of ART decreases progression to AIDS and HIV mortality by 50% (Marks, Gardner, Craw, & Crepaz, 2010; Mayer, 2011; Zolopa & Katz, 2012). The gold standard of care is to use at least two classes of ART, from which at least three different agents are selected (Aberg et al., 2009; Zolopa & Katz, 2012). ART classes include: nucleoside reverse transcriptase inhibitors (e.g., Retrovir, Videx, Hivid, Zerit, 3TC, Emtriva), nucleoside reverse transcriptase inhibitors (Viread), protease inhibitors (Crixivan, Invirase, Norvir, Viracept, Lexiva, Kaletra, Reyataz, Norvir), non-nucleoside reverse transcriptase inhibitors (Viramune, Rescriptor, Sustiva, Intelence), entry inhibitors (Fuzeon, Selzentry), and integrase inhibitors (Isentress). Each of the drug classes has unique actions against HIV infection. These medications carry complex pharmacokinetic and pharmacodynamic properties, and as such, they should be prescribed and monitored only by experienced HIV clinicians. Most classes of ART drugs also produce side effects that require monitoring and treatment. Patients should receive sufficient education about their medications, side effects, signs/symptoms that necessitate notification of a health provider, and the importance of strict maintenance to the medication regimen. The number of pills that a patient must consume daily ("pill burden"), the patient's ability to adhere to the regimen, costs, and comorbidities and immune status should all receive consideration when working with the patient to develop a treatment plan. All things considered, the treatment plan to which the patient is most willing to commit is the one he is most likely to follow and thus should be the one selected.

Sexual Health

Sexual health promotion is of paramount importance in primary care of HIV positive gay men (Mayer, Bush, et al., 2012). The patient's own views about his sexuality and disease process should be evaluated. Any perceived deficiencies should be addressed through health counseling and education from the appropriate professional. Patients should be educated about their disease process and receive coaching on the various ways that they can express their sexualities that minimize their chances of onward transmission of HIV. Patients should also receive education on what sources of information are reliable when researching their own disease processes and how it may impact aspects of their sexual expression that may include, for some, erection and ejaculation.

Prevention of other sexually transmitted infections (STIs) is critical for HIV positive gay men. HIV positive gay men are at increased risk for coinfection with other sexually transmitted pathogens (Bachmann et al., 2009; Pando et al., 2012; Rice et al., 2016). STIs common in gay HIV positive patients include human papilloma virus (HPV), hepatitis A, B, and C, gonorrhea, syphilis, chlamydia, and herpes 1 and 2 (Zolopa & Katz, 2012). Moreover, treatment of gonorrhea, chlamydia, and syphilis can significantly reduce the amount of HIV virus present at the urethral and anal mucosal sites—consequently decreasing the odds of onward HIV transmission to sexual partners (Modjarrad & Vermund, 2010). An HIV positive gay man should also be offered hepatitis A & B vaccinations if it is determined that he has not been previously vaccinated or if verification—either by patient recollection or chart documentation—is unavailable. The HPV vaccine is now recommended for MSM through age 26, especially for HIV positive MSM. High-intensity behavioral counseling and other evidence-based behavioral interventions should be considered for use in support of STI risk reduction. HIV positive gay men who have serodiscordant sexual partnerships should be considered for pre-exposure prophylaxis (PrEP) for the HIV negative partner along with high-frequency HIV screening for early detection and treatment in the event of seroconversion (Baeten et al., 2012; Grant et al., 2010; Thigpen et al., 2012). Sexual health care for HIV positive gay men is complex, requiring provider-patient collaborations to find strategies for achieving sexual expression and health maintenance goals (Mayer et al., 2016; Weinman, 2010).

Mental Health

Mental health and wellness is an integral and foundational aspect of HIV care for gay men (Batchelder, Safren, Mitchell, Ivardic, & O'Cleirigh, 2017). A comprehensive suicide assessment and screening should be conducted at the first clinical encounter, as HIV positive persons are two times more likely to experience depression and suicidal thoughts than HIV negative persons (Ciesla & Roberts, 2001). The health provider should be sensitive as to how the diagnosis of HIV and other STI

positive results are delivered to gay men, as studies have demonstrated that the manner in which the clinician communicates these results can alter the response and coping ability of the patient (Hult, Maurer, & Moskowitz, 2009). Some HIV positive gay men may also have internalized feelings of homophobia, which may be a contributing or compounding factor to their experiences of depressive symptoms. Internalized homophobia among HIV positive gay men has been linked both to increased risk of depression and to sexual risk behaviors (Ross, Rosser, & Neumaier, 2008). Linkages to psychological counseling services and support groups should be provided, wherever possible, as these have been shown to have beneficial effects on depressive symptoms (White et al., 2012). Pharmacological agents may also be necessary to support the patients' management of depression and anxiety. Given HIV positive gay men's elevated risk for developing depressive symptoms, health care providers should conduct a psychosocial assessment, even if only a brief one, at every clinical encounter and work with patients to develop a mental health plan of care and linkage to care, as appropriate.

E-Technology

As the numbers of uninsured HIV positive gay men increase, the need to treat, monitor, and educate such patients will also increase. Qualified clinicians may not always reside in the geographic location of clinical need. In such situations, clinicians may be able to conduct limited evaluations over the phone, through video conferencing, and through email (Hirshfield et al., 2016). This type of technology is best suited for follow-up evaluations, counseling, needs assessment, triage, prescription refills, and education. E-technology should not serve as an initial point of entry for physical examinations. E-technology may increase, as the numbers of insured may reach historic proportions within the context of the Affordable Health Care Act in the USA. Legal and ethical considerations must be evaluated and resolved as this emerging form of patient evaluation and treatment continues to evolve. E-technology may provide considerable relief for current gaps in access to care for HIV positive gay men across the country.

Directions for Future Research

With the passing of the Affordable Care Act (ACA) and the implementation of the National HIV/AIDS Strategy and HIV Care Continuum Initiative, the USA has begun a new chapter in the organization of health care practice approaches. This reorganization presents an optimal window for the emergence of comprehensive primary health care as an approach to HIV/AIDS care (Beyrer et al., 2012). The utilization of a comprehensive PHC approach will require research and innovation regarding how health care costs are managed (Basinga et al., 2010; Mayer et al.,

2016; Schoen et al., 2009), how health care teams are organized under ACA (Rittenhouse, Shortell, & Fisher, 2009), and the implications of multidisciplinary health care teams on HIV care quality outcomes (Mayer et al., 2016; Poulton and West, 1993; Sherer et al., 2002; Zaller, Gilliani, & Rich, 2007). Additional research should also explore how emerging solutions in data (e.g., electronic charts, local/regional patient information exchanges) and communication (telemedicine) systems can be harnessed to support more time-efficient, cost-effective, accessible, and client-centered health care services and expand access points into HIV care (Hirshfield et al., 2016; Schoen et al., 2012).

Test and treat interventions focus on reducing risk of onward transmission by suppressing the HIV viral load of HIV-infected individuals (Castel et al., 2016; Kalichman et al., 2010; Modjarrad & Vermund, 2010). Additionally, interventions that promote early linkage to and retention in care are needed to support quality outcomes for HIV positive gay men (Marks et al. 2010; Mayer, 2011; Gwadz et al., 2015; Mugavero, Norton, & Saag, 2011; Rachilis et al., 2016). It will also be important for future research to extend beyond clinical and behavioral factors that impact screening, medical care linkage and treatment towards investigating policies that interfere with the effective and efficient linkage to care (Mugavero et al. 2011; Riley et al., 2012). Although gay men generally reduce HIV transmission risk behaviors after receiving an HIV diagnosis, a substantial percentage of HIV positive gay men remain at increased risk for the onward transmission of HIV (Crepaz et al., 2009; Mayer, Bush, et al., 2012). This highlights the need for continued research evaluating innovative strategies for preventing the onward transmission of HIV to others (Safren et al., 2011; Serovich et al., 2009).

Conclusions

The comprehensive primary health care approach is a relevant practice model for working with HIV positive gay men. Within the comprehensive PHC approach, a more holistic engagement with the needs of HIV positive gay men can be accomplished (Beyrer et al., 2012; Bhatia & Rifkin, 2010). Public health practice has a long tradition of advocating for social justice reforms as interventions to improve health and wellness of vulnerable and marginalized populations (Nelson & Morrison-Beedy, 2012); however, increased attention must be given to educating nurses, physicians, and other members of the clinical team to adopt anti-racism, anti-oppression frameworks in their clinical practice (Nelson et al., 2014, 2016). The United States, through the National HIV/AIDS Strategy, has an opportunity to more fully adopt principles of comprehensive primary health care. Many of the priorities in the National HIV/AIDS Strategy are congruent with the comprehensive primary health care approach. These include expanding access to HIV primary care, maximizing the application of technological innovation in the primary and secondary prevention of HIV and the development of community-informed plans for the manner in which HIV prevention and care are organized and delivered within local communities

across the USA. Implementing the principles of comprehensive PHC will require that health care professionals push the boundaries and commit to social justice aims within their clinical practice (Dean & Fenton, 2010; Easley & Allen, 2007; Eliason, Dibble, & DeJoseph, 2010; Nelson et al., 2016) and work with partners outside of the health sector to help HIV positive gay men attain their wellness goals.

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