Examining Perceptions of Screening for HIV, PrEP, & COVID Vaccinations for Racial, Ethnic, Sex, and Gender Minorities in Clinical Settings

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HIV+COVID Screening & Testing Model

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Background

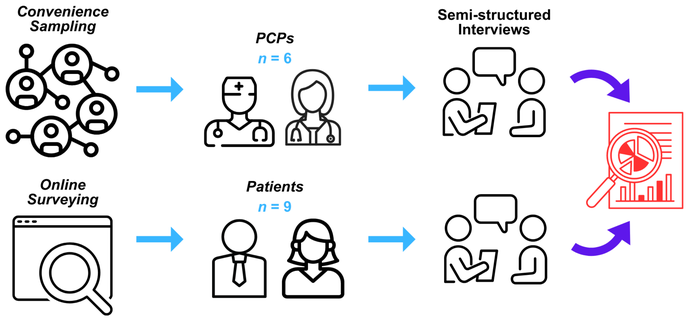
- Among those living with human immunodeficiency virus (HIV), historically excluded groups, those who are racial, ethnic, sex, and gender minorities, deal with a **greater HIV burden of disease** (HIV.gov, 2022).
- People from historically excluded groups have **significantly disproportionate COVID-related health outcomes** despite adequate vaccination status (Hill & Artiga, 2022).
- **COVID and HIV are also remarkably stigmatized**, directly impacting the health of racial, ethnic, sexual, and gender-minoritized patients.
- During the COVID pandemic, HIV has received significantly reduced attention with decreased HIV testing and diagnoses → **HIV is left unmanaged for many patients**.
- **The stigma stems from fear and misinformation – two factors best addressed in the primary care setting.**

Purpose

- **This study aimed to determined facilitators and barriers to HIV, PrEP, PEP, and COVID vaccination screenings for minoritized populations in clinical settings through qualitative research.**
- The facilitators and barriers identified from interviews with racial, ethnic, sex, and gender minoritized patients and primary care practitioners (PCPs) of the U.S. will inform continuing medical education training modules available to U.S. PCPs through the Two in One: HIV + COVID Screening and Testing Model.

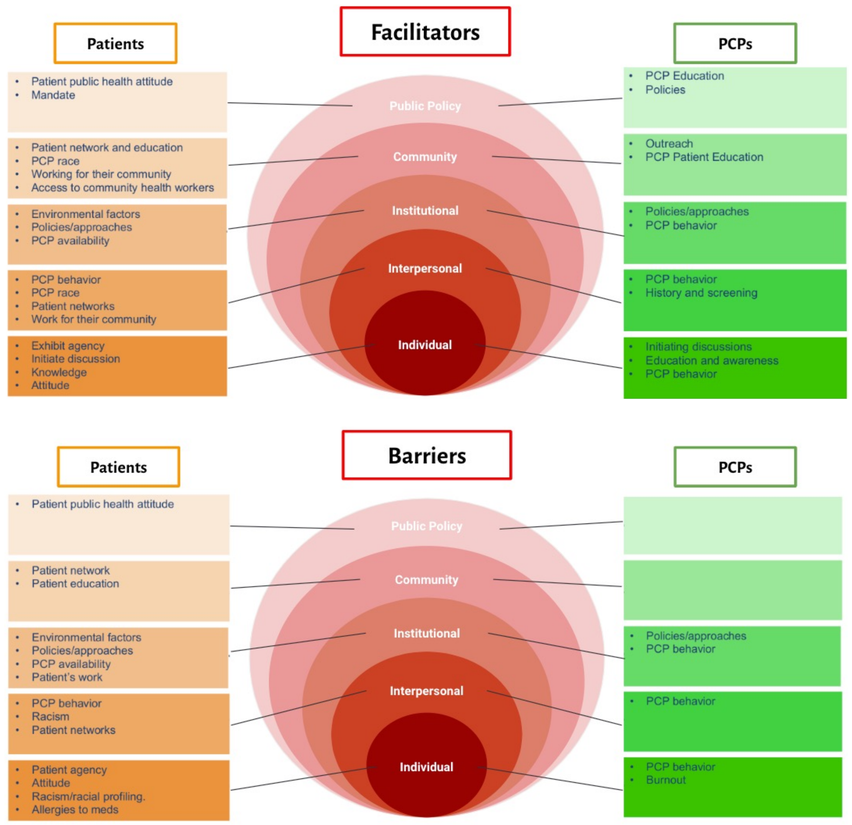
Methods

- **Critical Race Theory** (Bell, 1995) and **Queer Theory** (Alexander, 2017) stress the importance of centering BIPOC counter-narratives and queer voices in order to understand, disrupt, and reshape systems of power, as these groups are best able to speak to their humanity and experiences.



- Collected data was then organized under the **Socio-Ecological Model** (McLeroy, et al., 1988) given its intersectional lens that addresses how to undo harm and redistribute power and resources as patient education and clinical interventions have failed to address disparate outcomes that are multilevel and structural.

Findings



Patient's Reality

- [F] Role of public health mandates
- [B] HIV deprioritized + COVID rushed rollout
- [F] PCP race + Pt networks → knowledge
- [B] Negative narratives, myths, stigma
- [F] Access to health literate material, vaccines on-site, PCP testing recommendations, PCP availability, & positive environment
- [B] Lack of EMR access & opt-out testing
- [F] PCP similar race + supportive Pt networks
- [B] Non-friendly, discriminatory PCP behavior reflecting power imbalance
- [F] Pt exercise agency amidst racism + profiling
- [B] Pt fear + pressure to remain open is draining

PCP's Perception

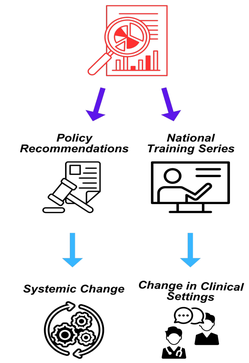
- [F] Role of health department + state auto-populated immunization records
- [B] None reported
- [F] 1 PCP mentioned importance of community outreach
- [B] Negative narratives, myths, stigma
- [F] Need access to Pt records and appreciate following policies/procedures
- [B] Competing demands and being affected by recall bias
- [-] Shared minimally being friendly and taking histories
- [F] PCPs are attuned to their role and responsibility to self-educate. Hyperaware of patient attitudes and beliefs.
- [B] PCPs experience burnout

Discussion

- **PCPs did not discuss the work patients do to ensure their own care**, such as the draining emotional work to remain open and the relational work of reaching out to networks of family and friends to understand aspects of their care.
- While patients noted the importance of PCP race concordance and PCP attitudes and behaviors, **PCPs did not bring up any interpersonal factors affecting care**.
- While patients PCPs were attuned to the systemic factors hindering them in their work life confusing COVID policies and competing demands on their time, **they did not raise any of the issues patients did about PCP availability, patient EMR access, and material at an appropriate health literacy level**.
- PCPs attend to individual-based, institutional-based, and policy-based facilitators to care, overlooking interpersonal-based and community-based facilitators.
- Patients and PCPs **align on the community-based barriers to care**.
- Depending on context and experience as a PCP or patient, **some of the facilitators doubled as barriers**.

Conclusions & Implications

- Many training gaps were identified through this qualitative research study.
- The findings and conclusions from this qualitative research study will **directly inform training modules for U.S.-based PCPs** under the Two in One Model.
- PCPs should **adopt culturally responsive communication (CRC) with patients** due to their lack of focus on interpersonal factors (Cohen & Goode, 1999).
- The study will also **inform policy recommendations** to routinize HIV, PrEP, PEP, and COVID screening in the same visit in primary care settings.



Funding & References

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