January 17, 2020

USPSTF

5600 Fishers Lane

Rockville, MD 20857

SUBJECT: Comments on Draft Recommendation Statement and Draft Evidence Review - Behavioral Counseling Interventions to Prevent Sexually Transmitted Infections

Dear U.S. Preventive Services Task Force,

Children's Hospital of Philadelphia (CHOP) is the region's largest pediatric health care network with over 30 clinical locations for primary and subspecialty care throughout Pennsylvania and New Jersey. Many of our sites provide prevention services, diagnosis, and treatment for sexually transmitted infections (STIs). In 2018, for example, the CHOP primary care network conducted 6,888 STI screenings, 4.9% of which were positive, representing 855 STIs diagnosed. Speaking from our perspective as clinicians and researchers with a particular interest in adolescent health and addressing the STI epidemic in our community, we appreciate the opportunity to provide comments on the U.S. Preventive Services Task Force (USPSTF) Draft Recommendation Statement and Draft Evidence Review on Behavioral Counseling Interventions to Prevent Sexually Transmitted Infections.

Given the consistently rising rates of STIs among adolescents and young adults in the United States, and recent data demonstrating that Philadelphia has the third highest STI rate in the country, we applaud the USPSTF in the timeliness of this review. Below, we present

commentary and recommendations in response to the USPSTF draft recommendations, organized by section. We have italicized the USPSTF text, with our bulleted responses below.

RECOMMENDATIONS AND BENEFITS:

1. "Assessment of Risk: All sexually active adolescents are at increased risk for STIs because of the high rates of STIs in this age group and should receive behavioral counseling interventions."

- We agree on the importance of behavioral counseling for all sexually active adolescents. In addition, we encourage the USPSTF to include a statement on the need for primary care providers to obtain a confidential sexual history from all adolescent patients. This recommendation is in-line with the guidelines from the American Academy of Pediatrics and Society for Adolescent Health and Medicine.[1,2] Ensuring a confidential exchange between a primary care provider and their adolescent patient is a critical upstream step to behavioral counseling. The sexual activity of adolescent patients is unlikely to be ascertained without providers taking a portion of the visit to speak with them alone. Unfortunately, in busy primary care practices, this practice is not always adhered to. In a review of medical records from our extensive health system by Goyal et al, only 21.2% of adolescents had a documented sexual history.[3] Comprehensive sexual history records also allows providers to tailor their counseling to the specific needs and health behaviors of their patients. For example, the behavioral STI counseling needed for a young male having unprotected anal intercourse in a male-male sexual relationship may differ substantially from that given to an adolescent female in a heterosexual relationship who is having condom-protected oral sex "most" of time. Lastly, given the rise of the use of "dating apps" or geosocial mobile applications used to identify sexual partners[4], we recommend that counseling also address this behavioral trend.

2. "Behavioral Counseling Interventions: Interventions that include group counseling and involve high total contact times (defined in the evidence review as more than 120 minutes), often delivered over multiple sessions, are associated with larger STI prevention effects. However, some less intensive interventions have been shown to reduce STI acquisition, increase condom use, or decrease number of sex partners."

- We applaud the USPSTF for emphasizing that although effect sizes may be smaller, interventions less than two hours in length have demonstrated gains, and that interventions longer than two hours may be infeasible to deliver in the office setting. Small effects sizes that are spread across large populations could have greater impact than large effects size interventions that never occur.
- In addition, we recommend including evidence that interventions targeting co-morbid risk factors for sexual risk behavior—including substance use and depression—may have greater effect on sexual health outcomes than interventions focused on STIs alone.[5] Given the strong relationships between sexual risk behavior, substance use, and depression, providers should consider counseling and linkage to services to treat these co-morbidities that increase STI risk.[6-9]

RESEARCH NEEDS AND GAPS:

1. "Most studies identified by the USPSTF enrolled girls, women, and men at increased risk for STI acquisition. More research is needed in sexually active boys; pregnant persons; gay, bisexual, or transgender persons; and older adults at increased risk; as well as in adolescents who are not yet sexually active. Research on interventions that engage couples or sex partners of primary care patients is also needed."

- We agree with the USPSTF regarding the need for additional research that considers the varied and intersectional identities that are at risk for STIs. In particularly, we agree with highlighting sexual minority adolescents as a vulnerable population that has received insufficient attention. We want to highlight that the term "gay" used in the revised recommendations is most often used in the vernacular applying to cisgender males. This language may be misinterpreted to exclude females having same-sex relationships. We recommend broadening the focus on sexual minorities to include lesbian adolescents. While female adolescents having only same-sex relationships are at lower risk of STI and HIV acquisition than their heterosexual peers, they are still at substantial risk, particularly given the burden of oral gonorrhea and chlamydia. In addition, data demonstrate that sexual orientation may be fluid over the lifespan, and some females in same-sex-only relationships may engage in heterosexual sexual relationships in the future. Subltle changes in the language of the revised guidelines can ensure that the intended call for action across multiple vulnerable populations hits home.
- People using pre-exposure prophylaxis (PrEP) are high risk for STIs. Recent data demonstrate an increased burden of STIs in PrEP users.[10,11] Therefore, this population merits specific mention as a population in need of interventions around behavioral STI risk reduction. Providers must maintain vigilance engaging PrEP users in STI/HIV prevention counseling and screening. We recommend including in the revised USPSTF recommendations a statement highlighting for providers the need for continued STI/HIV prevention counseling and screening in users of PrEP.

2. *"Few trials incorporated sexual risk assessment performed by primary care providers and less than one half of trials assessed interventions delivered by physicians, nurses, psychologists, or other health professionals. Because many trials were conducted in STI*

clinics, research that is more applicable to general primary care populations would be valuable, such as trials that test interventions delivered or endorsed by primary care providers for patients who report increased STI risk based on well-defined risk assessment methods."

- We agree with the USPSTF statement that future research is needed to develop counseling scripts and interventions that are deliverable by primary care physicians, or within the primary care office. Given that limited visit time, provider knowledge, and provider self-efficacy are substantial barriers to STI counseling in the primary care office[12,13], we recommend adding a specific statement that implementation science research and hybrid implementation-effectiveness trials are needed to identify effective strategies for integrating STI counseling into the primary care setting.
- Finally, we feel it is important that the USPSTF acknowledge that the changing policy landscape has made it more challenging for some vulnerable populations to access HIV/STI prevention and screening services in both traditional and non-traditional settings. This will undoubtedly impact care delivery among providers who utilize the USPSTF guidelines. We recommend acknowledging these challenge and encouraging providers and administrators at care sites to be thoughtful, innovating and resourceful in considering how these recommendations can be used to update their current processes to ensure maximal impact.

Thank you for your process transparency and for taking the time to consider our feedback. We look forward to seeing the final version of the recommendation statement and welcome an opportunity to continue to engage with you.

Sincerely,

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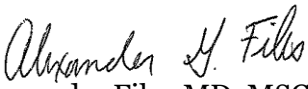

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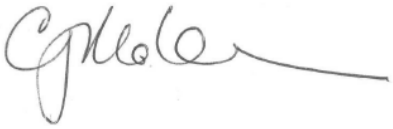

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