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A Qualitative Exploration of Facilitators for Health Service Use among Aging Gay Men Living with HIV

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Abstract

Using Anderson's Health Behavioral Model of Health Service Use, this study explores factors facilitating health service use among aging gay men living with HIV. Qualitative data from 10 participants recruited from a federally qualified health center were analyzed using theoretical thematic analysis. Results shown to facilitate health service use include an existing need for services in the form of HIV management; predisposing factors of age and the development of resilience in the face of stigmatizing experiences related to their sexual identity and health status; and enabling influences including comfort with medical providers, providers knowledgeable in lesbian, gay, bisexual, transgender, and queer issues, and sexual concordant providers. Need for services, predisposing factors, and enabling factors are discussed in relation, as well as each factor's unique implications for this population. Results from this study may be used to improve service use and provides tangible clinical recommendations.

Keywords

gay men, aging, HIV, health service use

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Background

Aging gay men living with HIV consist of a diverse and growing group of individuals often overlooked in contemporary lesbian, gay, bisexual, and transgender (LGBT) and HIV research.[1-3] Although exact census estimates do not currently exist, it is estimated that over 2.5 million older LGBT adults are currently living in the United States, 9% of whom are living with HIV.[2] Influenced by a unique social history including the medicalization of homosexuality, as well as the AIDS crisis that fundamentally altered societal views toward this population for decades, aging gay men living with HIV have developed a health profile distinct from both their heterosexual and younger gay counterparts.[1,4-6] Research suggests this population experiences higher rates of chronic illness, substance use, and behavioral health concerns including increased rates of cardiovascular disorders, certain cancers, and substance use, depression, and suicidal ideation.[2,7-11]

Of particular concern are the unique health service use behaviors among aging gay men living with HIV, which are found to be associated with negative health outcomes.[6,8,12,13] Health service use is defined as the process of consuming health services that are available and accessible within the environment.[11] Previous research suggests this population uses health services less often than heterosexual men living with HIV, as well as younger gay men.[14,15] Additionally, aging gay men living with HIV experience worse health outcomes as a result of their service use behaviors compared to aging HIV-negative gay men.[2]

Facilitators defined as any factors including objective aspects, such as access to health insurance and services, and subjective aspects, including a desire for nonjudgmental and trusting services and provider expertise in LGBT and HIV issues, are limited in number. However, health services that include these objective and subjective aspects have been identified to show an improvement in service quality as well as an increased use of health services for LGBT and HIV-positive individuals.[16-18] To these authors' knowledge, no study has examined factors for health service use among aging gay men living with HIV specifically and in tandem. In order to identify

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What Do We Already Know About This Topic?

Aging gay men living with HIV experience health disparities at higher rates when compared to both their aging heterosexual and younger gay counterparts including disparities in health service use, which is a critical aspect in identifying and reducing chronic health and behavioral health issues.

How Does Your Research Contribute to the Field?

This research explores the critical aspect of health service use among aging gay men living with HIV, which has not been explored in-depth previously; in particular, this study identifies facilitators for health service use medical providers and other health-care professionals may consider and incorporate into their work with these patients.

What Are Your Research's Implications Toward Theory, Practice, or Policy?

Results of this study provide both theoretical and practical implications for working with aging gay men living with HIV, including findings that support the use of Anderson's Health Behavioral Model of Health Service Use for this population as a means of synthesizing facilitators for health service use to improve services and practice considerations such as creating and maintaining supportive relationships and encouraging the development of coping skills used to reduce the impact of barriers to health service use.

multilevel intervening factors beyond the more general LGBT and HIV health service use facilitators, in-depth exploration into this specific population's health service use, in particular what facilitating factors are seen to engage and continue service use, is warranted to expand current scholarship on the needs of this group.

The Behavioral Model of Health Service Use is a widely used framework to explore multilevel intervening factors influencing health service use.[19,20] The model describes multiple dimensions of health service use, including need for services, predisposing factors, and enabling factors. The need for services is an individual's subjective view of their own quality of health which can influence the use of services. Need for services may also be evaluated by a health-care provider altering one's view of their beliefs toward the need for health services once an individual has engaged in services.[20] Predisposing factors include aspects seen to predict the use of services based on factors such as demography, psychosocial aspects, and preconceived health beliefs.[20-22] Enabling factors are those that support the use of health services, including personal, family, and community resources, such as health insurance, socioeconomic status, availability/access to health services, and quality of health services.[20,23]

Anderson's Behavioral Model of Health Service Use has been used frequently to examine service use behaviors among sexual minority groups[18,22,24,25] and aging persons living with HIV,[26] although not in tandem. Therefore, using this model as a sensitizing framework, this article explores factors facilitating health service use among aging gay men living with HIV engaged in consistent health services. It is hypothesized health service use facilitators unique to this group given their age, sexual identity, and HIV status will emerge beyond those seen in the more general LGBT and HIV-positive populations.

Methods

Study Design and Participants

This study uses data from 10 (n = 10) semistructured interviews with aging gay men living with HIV. Participants were recruited from a federally qualified health center (FQHC) in Philadelphia, Pennsylvania. Homogeneity of services enabled researchers to focus on a sample whose health service use experiences were similarly seen as an advantage when examining unstudied phenomenon in-depth.[27,28] Participants eligible for this study were limited to cis-gender men identifying as gay/homosexual and living with HIV. In addition, based on previous work on this population, these men were required to be aged 50 years or older to be considered an aging adult.[7,29,30] Participants were required to be engaged in consistent health service use defined as one medical visit every 4 months.[31]

A qualitative research design was used to gain in-depth contextual data. To date, factors facilitating health service use among LGBT and HIV-positive populations have been quantitative in scope, providing useful information on health service use more broadly.[16-18] A critical gap remains in understanding facilitators specific to aging gay men living with HIV, as well as in-depth explanations of what facilitators may mean in the context of this population.

Data Collection and Recruitment

Data collection occurred during Spring 2018. Participants were recruited using purposive sampling where potential participants were recruited based on their experience using health services. Flyers were posted throughout the FQHC where interested participants were encouraged to contact the primary researcher via telephone number provided on the flyer. Medical and case management staff also participated in recruitment efforts by reaching out to patients whom they felt qualified for the study. A total of 10 participants were recruited for this study. A sample of this size was used to explore phenomenon in-depth per qualitative methods design. Recruitment was limited to 10 participants as saturation became clear based on initial analysis. Appropriate sample size for a study of this design ranges from 6 to 25 depending on the scope of the study.[32-35]

Table 1. Participant Demographics.

	N = 10	%
Age (mean)	58.3	
Race		
African American/black	6	60.0
Caucasian/white	4	40.0
Living situation		
Independent	6	60.0
With family/friends	2	20.0
Homeless	1	10.0
Other	1	10.0
Education		
High school graduate	3	30.0
Some college/associates degree	2	20.0
Bachelor's degree	4	40.0
Graduate degree or higher	1	10.0
Employment status		
Employed full time	2	20.0
Employed part time	2	20.0
Unemployed/other	2	20.0
Disabled	4	40.0
Insured (health)	10	100

Interview

Interviews were scheduled in 1-hour increments and conducted by the primary researcher. During each interview, participants were provided information about the purpose and scope of the study. Participants were able to end participation at any point during the interview. Participants were provided a $25 Visa gift card as incentive. Interviews were recorded and transcribed verbatim.

The interview consisted of a semistructured format which included close-ended demographic questions (Tables 1 and 2) and open-ended questions. Examples of open-ended questions include the following: "If you could change anything about your current doctor or doctor's office, what would you change?"; "When did you begin telling your doctor that you were gay?"; and "How has identifying as a gay man effected the health care you've received if at all?" A list of interview questions are presented in Appendix A.

Analysis

Analysis was conducted using NVivo 12. Data were analyzed using theoretical thematic analysis where specific theoretical perspective guides the development of themes.[33,36-38] Anderson's Health-Care Utilization Model was used to guide the analysis. The analysis used an essentialist approach reporting the experiences of participants based on the meaning or reality placed on events or concepts as defined by the participant.[36] Analysis was based on the 6 steps toward thematic analysis as proposed by Braun and Clarke.[36] In addition, Lincoln and Guba's[39] criteria for trustworthiness in qualitative data analysis were used to increase rigor. Investigator triangulation, discussions of reflexivity, audit trails, and calculated intercoder reliability are examples of these criteria used in this study.[39,40]

Following each interview, initial thoughts and ideas about the data were gathered. These thoughts were then compiled and shared with the secondary researcher helping guide analysis.[36,41] Initially, 3 transcripts were independently analyzed, creating a list of codes seen to encourage or aid in health service use. Three additional transcripts were then coded continuing to refine and create codes. New codes were added to the codebook after consensus between researchers was met. The final 4 interviews were then reviewed using the same process. For this study, thematic saturation was achieved at the seventh interview and confirmed with the analysis of 3 additional transcripts. A 91% degree of consensus was achieved during this step of analysis. All transcripts were then independently reviewed using the final codebook, where content coded was compared and consensus reached. A third researcher was available for consultation, although was not needed as consensus was able to be reached in all cases.

Codes were then organized into themes using the 3 factors described by Anderson[19,20] by connecting codes with one another as described by the thematic analysis approach.[33,36-38] Themes and their codes were reviewed where consensus was reached between researchers ensuring codes fell under the appropriate theme.

Ethical Approval and Informed Consent

This study was approved by the University of Southern California's University Park institutional review board (IRB) (approval no. UP-17-00664). University Park IRB determined that this study meets the requirements outlined in 45 CFR 46.101(b) category (2) and qualifies for exemption from IRB review. The need for written informed consent was waived. An information sheet was provided to participants outlining study procedures. Participants were informed their participation was voluntary and participation could be stopped at any time.

Results

Participant characteristics and demographics, including aliases used, are presented in Tables 1 and 2. The findings of this study both extend our current understanding and support previous research on the health service use among aging gay men living with HIV. The analysis revealed 3 themes consistent with Anderson's Behavioral Model of Health Service Use: need for services, predisposing factors, and enabling factors. Each theme consisted of multiple codes relating to specific facilitators for health service use both generally and specific to this population. Each theme and its associated codes are described independently, followed by a discussion of the themes and codes as related to health service facilitation.

Need Factors

Two types of need factors emerged in this analysis. The first type of need focused on subjective need for services. The second need factor was an objective need for services or

Table 2. Participant Characteristics.

Participant	Name (Alias)	Age	Race	Education	Employment	Income/ Monthly	Living Situation	Insured
1	James	57	Black/AA	High school diploma/GED	No, due to disability	775	Independently	Yes
2	Michael	63	White/non-Hispanic	Graduate degree	No, due to disability	1200	Independently	Yes
3	Charles	54	White/non-Hispanic	Bachelor's degree	Full time	3200	Other	Yes
4	Douglas	69	White/non-Hispanic	Bachelor's degree	Part time	1700	Independently	Yes
5	Stephen	55	Black/AA	Bachelor's degree	Part time	1200	With family	Yes
6	Kevin	60	Black/AA	Bachelor's degree	Retired	1500	Independently	Yes
7	George	54	White/non-Hispanic	High school diploma/GED	No, due to disability	1700	Independently	Yes
8	Carl	50	Black/AA	Associates degree	Full-time	500	With family	Yes
9	Philip	60	Black/AA	High school diploma/GED	No, due to disability	1026	Independently	Yes
10	Matthew	61	Black/AA	Some college	No, but looking for work	0	Currently homeless	Yes

Abbreviations: AA, African American; GED, General Educational Development.

indications from a medical provider that need was critical. Subjective and objective needs are consistent with Anderson's Behavioral Model.[19,20]

Subjective need. Given all participants were living with HIV, subjective need for care centered on their HIV management. Of the 10 participants, 9 discussed how experiencing symptoms, which would later be diagnosed as HIV, led to their initial use of health services. Carl, a 50-year-old African American participant, explained, "The first time I got sick, I thought, okay, that's unusual. I don't get sick . . . it was 1991, but in 1989 I got raped. The day I got sick, it was like, "I don't catch colds. I don't get sick." Charles, a 54-year-old white participant, described, "I found out I was HIV positive in 1990, that would have been the first time that I would have entered medical care." Beyond initial symptomatology and diagnosis, many participants described how managing HIV keeps them using services regularly. "You need to be more on top of taking these pills and I do all that. It just becomes more about paying attention to your body and what your body's telling you and then addressing it, basically" continued Charles. Philip, a 60-year-old African American participant, explained how his HIV status has helped him advocate for himself when using services, "Well, there's nobody else but me and I'm learning to advocate for myself. It's been 20 something plus years since I've been HIV positive. I have to do this."

Objective need. Endorsement of objective need for service use focused on medical provider's verification of a need for service use and suggestions for additional services usually requiring a referral. These referrals were not always directly related to participant's HIV status as Philip explained, "I came here to see my health care provider . . . and he sent me to [a local hospital]. I had a couple of bad bouts. They did imaging and they found I had kidney stones."

Predisposing Factors

The majority of predisposing factors shown to facilitate service use were related to participant's psychosocial characteristics associated with their multiple identities. Identities that were associated with health service use included sexual minority identity (gay), HIV-positive identity, and identity as an aging adult. Although participants identified experiences related to their sexual identity and HIV status which were seen to hinder health service use, the development of resilience in the face of these experiences was seen as the drivers for successful health service use. Resilience as a facilitator for health service use, therefore, buffered negative past experiences and is what impacted successful health service use for these men later in life. Age was seen to facilitate health service use due to a sense of maturity and responsibility to their personal health and well-being.

Resilience. The presence of resilience appeared to lessen the impact of negative experiences within the health-care system. The ability to recover and grow from negative experiences ultimately improved the health-care use for many of these participants. Matthew, a 61-year-old African American participant, described resilience as "having something within yourself, some inner faith to fall back on . . . your parents had to instill something within you to fall back on, or you find something in your journey through life to fall back on that works for you." Stephen, a 55-year-old African American participant, described the importance of practicing resilience,

> How do you go about loving yourself? These are the cards that you're dealt with. Nobody chooses to be gay. Nobody chooses to be black. You don't get these choices . . . play the hand that you're dealt with, be the best that you can be. Don't listen to those naysayers because they're a ton of them out there. They're going to judge you, they're going to judge you because you're black, they're going to judge you because you are short . . . you're going to always be judged on something but love yourself, love who you are. If people don't like you, well, some people don't like you, other people are going to love you. Find those people that love you.

Specifically, resilience in the face of sexual minority identity and HIV-related stigma was seen to improve health service use.

Sexual minority identity resilience. All participants reported their sexual identity as critical to their health service use. While most participants experienced stigma related to their sexual identity within the health-care system, over half detailed how stigmatizing events caused them to change and improve their service use. "Onetime at [a local hospital], a lady told me, it's okay to commit suicide. I looked at her like, what the fuck? After she told me that, I was like, I can't go there anymore. I left [that hospital]." (Carl) Another participant described how experiencing stigma from a medical provider caused him to terminate and find better services. He went on to explain that after years of psychotherapy, he was able to shift his perspective on the experience.

> The doctor said 'Well, you shouldn't be having sex with men.' He was very judgmental and I said I would never, ever be judged again. I had to terminate. Get those weeds out of your village. Just uproot them, throw them away. Because you don't need as a gay man, as a gay woman . . . you don't need that extra crap in your life. You have to love you, you have to choose and this is the state that has taken years in therapy. (Stephen)

HIV resilience. The entire sample indicated their identity as an individual living with HIV influenced service use in some way. Similar to sexual identity, these negative experiences were mitigated by the presence of resilience. One participant described a stigmatizing experience related to his HIV-positive identity that led him to shop around for a medical provider until he began seeing his current medical provider.

> My God, the day I came in and told [my provider] I had gone for an HIV test and it come back positive, he flipped out. He was totally ignorant about the whole thing. There were different doctors in variant degrees that were that way. (Michael)

Age. The majority of participants identified age as a facilitator for health service use due to a comfort and acceptance of who they have become as individuals and an appreciation of the life and obstacles they have overcome, especially as they recall experiences during earlier years, which they considered stigmatizing or discriminatory largely based on their sexual identity and/or HIV status. "As you grow aging, you grow more mature and realize this person is providing me a service, and so if I can't be honest and open with them, I am not going to get the service that I need" (Stephen). Kevin, a 60-year-old African American participant, said,

> I think by [the time you are aging] you kind of know who you are and what you want and you don't have to prove anything and I think by the time you're 50, you seem to take better care of yourself. To be honest, turning 50 wasn't a big deal, turning 60 was and still is. I can't believe I'm 60 years old, I never thought I would live to 60.

Enabling Factors

Enabling factors facilitating health service use consisted mainly of quality of services issues largely centered on medical provider characteristics, including comfort with medical providers; medical provider knowledge and experience with lesbian, gay, bisexual, transgender, and queer (LGBTQ) patients; and sexual identity disclosure by the medical provider. Additionally, social support was seen to improve health service use among this sample.

Provider characteristics. Providers able to encourage a comfortable and empathic relationship with their patients while demonstrating LGBT-specific medical knowledge were seen to promote consistent service use. Additionally, sexual minority concordant providers were shown to improve both engagement and consistent use of services, specifically for this sample.

Feeling comfortable with a medical provider was the most frequently endorsed facilitator among the participants. Kevin, the 60-year-old African American participant, stated, "I would say go somewhere where you feel comfortable where you can talk about everything." Kevin continued,

> Over and over again, I've heard people say, I would never discuss that with my doctor. I can't imagine going to a doctor where you can't discuss everything, because then what's the point of going? That would be the first thing I would say, is you have to be comfortable with the doctor that you're with.

Charles, the 54-year-old white participant, described that comfort with a medical provider includes a nonjudgment attitude toward sexual behavior, "I'm into some sexual activity that requires checkups that other people don't require. The most important thing is I want to feel comfortable with my doctor. Sometimes you go to these places and it's a reward to be comfortable." Participants also discussed the importance of their medical provider acknowledging a comfort with LGBTQ patients. James, a 57-year-old participant, explained how his medical provider's patient population makes him feel comfortable,

> I can be more open with my doctor because they are dealing with a high percentage of homosexual patients, that makes me more comfortable. I would still be going to a doctor but I'd probably be hopping from doctor to doctor until I found the one I was really comfortable with. I went to one primary care doctor for a very long time. Then I came here, and I have had three providers. Through each one of those, we had to build that relationship. I don't jump off with that trust factor, I have to get a chance to know you and to trust you.

The participants described ways a provider can promote comfortable relationships. A provider who displays empathy was seen to promote consistent health service use. George, a 54-year-old white participant, stated,

> He takes time, he looks you in the eyes, he asks you major questions, you show him picture of your personal life, he gets into your personal life, he likes your hobbies. I would say he is also like a psychiatrist on top of it. I do and I believe this, I do believe in my heart, he is like that.

Other participants said similar statements. “Be there when I need them, obviously. They listen, they understand, they help you as much as they can” (Matthew) and “He is very sympathetic and very understanding.” (Michael)

A medical provider who is knowledgeable about LGBTQ health issues was endorsed by the majority of participants. “I think being gay, there are issues that I have that other places wouldn’t look for or see . . . I fear issues that we have as gay men, like having anal sex and other things that other people don’t have” (Charles). “[Disclosing sexual identity] keeps things more honest. If something’s wrong, at least they know what to look for. It might be something that I might not think could be caused sexually and they would know to look for that” (James). “[My provider], he was gay, gave me information every time I saw him. He was up on every drug, every trial, every new drug that came out. He went to all the symposiums. I mean, he knew it all,” stated Philip, a 60-year-old African American participant.

Over half of participants acknowledged having a provider who discloses they are gay facilitates health service use. One participant explained, “[Gay providers] seem to have more understanding. I don’t know how to explain it. Straight doctors don’t have that innate ability to reach in and talk to you and understand what you’re going through” (Matthew). Specifically, having a gay medical provider was seen to improve comfort beyond having an emphatic and committed provider, “[My medical provider] made me feel very comfortable, and I felt even more comfortable once I found out he was gay, because I felt like he could understand me.” (James) Another participant said,

> I would rather have a gay doctor, I think. Because I just feel more comfortable with that. I never thought I could have a non-gay doctor that I would feel comfortable with. I feel as though I can be more open about who I am and if I have any questions because sometimes we talk about everything. We talk about sex and there’s nothing that I can’t ask him. I would feel very uncomfortable talking to somebody who wasn’t gay, to be honest. (Kevin)

Social support. Having a social support system was seen to facilitate health service use. The majority of participants who discussed social support acknowledged that they had a small social network but the number of people in their network was not as important as the quality of the relationships,

> I survived, thank God I had good friends and my family who were very good to me and supported me and whenever I needed something they were by my side, I have to say it wasn’t a large network but it was a very loyal network. That’s what got me through. (Kevin)

Discussion

Various facilitators for health service use among this population emerged using Anderson’s Behavioral Health Model of Service Use. As supported by Anderson,[19,20] need for services, predisposing factors, and enabling factors appeared from the data as themes. Need for services due to the necessity for HIV management was seen as critical for health service use initiation. Predisposing factors strengthening the use of services included age and the development of resilience. Enabling factors largely centered on provider characteristics and were seen as the most critical set of facilitators for consistent service use among this sample.

Living with HIV was identified as the major need but was augmented by age as an additional motivator for the need for health service use. Participant’s motivation for initiating services centered on the need felt to monitor their health. In addition to participant’s subjective need, medical provider’s confirmation of participant’s subjective need was identified as a facilitator for service use. Once service use has been initiated, predisposing and enabling factors were shown to improve consistency of care.

Once service use has initiated, predisposing factors were seen to mitigate the presence of stigma and discrimination experienced either past or present, which may otherwise lead to service discontinuation as described by many participants. Over half of the participants discussed previous negative experiences with health-care providers, where stigma and discrimination associated with their sexual identity and/or HIV status caused them to discontinue care and search for more inclusive and supportive services despite their need for care. With age came a sense of resilience in the face of stigmatizing experiences. Participants described the process of developing resilience as a result of their past experiences by which aging was seen to mitigate experiences of stigma and improve resilience via maturation. Age as a vehicle for the development of resilience is consistent with previous work with aging adults living with stigmatized chronic health conditions,[42,43] although previous studies have also found opposing results, suggesting older age is associated with a lack of care, social isolation, and poorer overall health outcomes as a result of triple stigma (ie, sexual minority, HIV, and older adult statuses) partly due to a lack of sexual minority identity disclosure and hesitation resulting from past negative experiences within the health-care system.[4] These contradictory results may be due to these men being engaged in consistent health use where most have found a level of comfort with their medical provider which has been linked to health-related resilience, a patient-oriented approach to care led by medical providers.[44] Additional research is therefore needed exploring the relationship between age, resilience, and health disparities.

A provider’s approach to care may aid in the development of resilience and thereby facilitate consistent care. Provider characteristics emerged as the most endorsed enabling factor in this study. Comfort with a medical provider because of their acceptance and support of participant’s sexual identity, HIV status, and older age was the most supported factor contributing to service use. Comfort for this sample encompassed medical providers who were able to facilitate a meaningful and nonjudgmental relationship through the use of empathy. Studies among the general population support the importance of provider comfort and empathy.[45,46]

Medical providers who demonstrate knowledge of LGBTQ-specific health issues was seen as a facilitator for service use. Previous work has identified the importance of LGBTQ cultural awareness training for medical providers,[47] while acknowledging the lack of LGBTQ-specific health training in current medical school curriculum.[48] The lack of formal training has been shown to impact the comfort medical providers are able to share with their LGBT patients,[49,50] thereby relating LGBTQ knowledge to comfort.

A medical provider who discloses their sexual minority identity was associated with both comfort and knowledge. Specifically for this sample, a sexual concordant provider was seen as protective. Participants explained a sexual concordant provider is better able to understand their unique health concerns as gay men. Little is known about the benefits of sexual concordant providers, although previous studies on racial/ethnic minority groups have shown racial/ethnic concordant providers may improve service use among their patients.[51-53] There are potential risks associated with disclosing sexual identity among medical providers, including termination of services by patients following disclosure,[54,55] making a sexual minority provider's decision to disclose complex. Additional work is needed to explore the implications of provider sexual identity disclosure on health service use and the potential benefits of sexual concordant providers.

Finally, social support was seen to facilitate service use. Although the majority of this sample had small social networks, those networks were seen as beneficial to their service use. Although the majority of this sample had social support, social isolation continues to be a major issue for many older adults, particularly for sexual minority and HIV-positive individuals.[4] Social support's influence on health service use has been widely documented.[56-58]

This study is not without limitations. Participants were recruited from the same FQHC in Philadelphia, Pennsylvania, limiting the applicability of these results to health centers not designated with this qualification. Philadelphia's large urban environment further limits the generalizability of results to smaller metropolitan and rural areas. This study focused on facilitators for health service use, resulting in findings that were limited to aspects seen to promote health service use. Although discussed in relation to facilitators, aspects hindering health service use would be useful to explore more directly in future studies. In future studies, the addition of a control group would be beneficial to compare findings examining whether results are unique to this target population specifically. Despite these limitations, the findings of this study expand current knowledge of facilitators of health service use among this population. A strength of this study is its homogenous sample allowing for a targeting examination of unique health service use facilitators.

Conclusions

This study provides insight into facilitators for health service use among aging gay men living with HIV using Anderson's Behavioral Model of Service Use as a theoretical guide. These facilitators, especially enabling factors, may be used to improve service use among this population. Based on the findings of this study, service use may be enriched through additional LGBTQ health-related trainings, disclosure of the medical provider's sexual minority identity when appropriate, and developing resilience. Additional work is needed to further explore these concepts and their general applicability, especially the impact of sexual concordant medical provider's with a larger representative sample.

Appendix A. Semistructured Interview Guide.

Opening questions:

1. When was the last time you went to the doctor's office for you own health?
2. How often do you visit the doctor's office for your own health?
3. Are you having any difficulty getting to your doctor's office? Yes or No.
    a. If yes, what makes getting there difficult?
    b. If no, what about your current situation makes it easier to get to your doctor?
4. Do you feel like your current doctor cares about you and your health?
    a. If yes, what makes you feel like your doctor cares about you?
    b. If no, what makes you feel like your doctor does not care about you?
5. If you could change anything about your current doctor or doctor's office, what would you change?

Identity questions

1. When do you begin identifying as gay? (Put these date on the calendar)
2. When did you begin telling your doctor that you were gay? (Put these date on the calendar)
3. How has identifying as a gay man changed how you choose a doctor, if at all?
4. Has identifying as a gay man affected the health care you've received? (If so, place these data one the calendar)
    a. If so, what happen?

Health behavior questions (using life history calendar)

1. Have you ever had a negative experience with a doctor or doctor's office (including hospital visits)? (Put these data on the calendar)
    a. If yes, what happened?
    b. If no, skip to next question.
2. Has your sexual orientation ever had an impact on your experience with a doctor or doctor's office?
3. How has visiting the doctor changed over time for you? (Put these data on the calendar)
4. What is something your doctor or doctor's office do to make your experience better as a gay man?
5. What advice would you give young gay men about their health?

Concluding questions

1. Did you enjoy doing this interview?
2. Would you recommend any of your friends to do this interview to learn more about their health?
3. What would change or add to this interview?

End

Authors' Note

All participants provided informed consent prior to enrollment in the study. Written informed consent was waived by the IRB participants were provided an information sheet.

Declaration of Conflicting Interests

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References

1. Addis S, Davies M, Greene G, Macbride-Stewart S, Shepherd M. The health, social care and housing needs of lesbian, gay, bisexual and transgender older people: a review of the literature. *Health Soc Care Community*. 2009;17(6):647–658. doi:10.1111/j.1365-2524.2009.00866.x.
2. Choi SK, Meyer IH. *LGBT Aging: A Review of Research Findings, Needs, and Policy Implications*. Los Angeles: The Williams Institute; 2016.
3. Mulé NJ, Ross LE, Deeprose B, et al. Promoting LGBT health and wellbeing through inclusive policy development. *Int J Equity Health*. 2009;8:18. doi:10.1186/1475-9276-8-18.
4. Fredriksen-Goldsen KI, Kim HJ, Barkan SE, Muraco A, Hoy-Ellis CP. Health disparities among lesbian, gay, and bisexual older adults: results from a population-based study (author abstract). *Am J Public Health*. 2013;103(10):1802–1809. doi:10.2105/AJPH.2012.301110.
5. Fredriksen-Goldsen KI, Kim HW, Bryan AE, Shiu CS, Emlet CA. The cascading effects of marginalization and pathways of resilience in attaining good health among LGBT aging adults. *Gerontologist*. 2017;57(suppl 1):S72–S83.
6. David S, Knight BG. Stress and coping among gay men: age and ethnic differences. *Psychol Aging*. 2008;23(1):62–69. doi:10.1037/0882-7974.23.1.62.
7. Daley A, Macdonnell J. Gender, sexuality and the discursive representation of access and equity in health services literature: implications for LGBT communities. *Int J Equity Health*. 2011;10(1):40. doi:10.1186/1475-9276-10-40.
8. Dahlhamer JM, Galinsky AM, Joestl SS, Ward BW. Barriers to health care among adults identifying as sexual minorities: a US national study. *Am J Public Health*. 2016;106(6):1116–1122.
9. Frost DM, Lehavot K, Meyer IH. *Minority Stress and Physical Health Among Sexual Minorities*. Los Angeles, CA: The Williams Institute, University of California, Los Angeles School of Law; 2011.
10. Lelutiu-Weinberger C, Pachankis J, Golub S, Walker J, Bamonte A, Parsons J. Age cohort differences in the effects of gay-related stigma, anxiety and identification with the gay community on sexual risk and substance use. *AIDS Behav*. 2013;7(1):340–349. doi:10.1007/s10461-011-0070-4.
11. Mayer K, Bradford J, Makadon H, Stall R, Goldhammer H, Landers S. Sexual and gender minority health: what we know and what needs to be done. *Am J Public Health*. 2008;98(6):989–995.
12. Alencar Albuquerque G, de Lima Garcia C, da Silva Quirino G, et al. Access to health services by lesbian, gay, bisexual, and transgender persons: systematic literature review. *BMC Int Health Hum Rights*. 2016;16(2):2. doi:10.1186/s12914-015-0072-9.
13. Heck JE, Sell RL, Gorin SS. Health care access among individuals involved in same-sex relationships. *Am J Public Health*. 2006;96,1111–1118. doi:10.2105/AJPH.2005.062661.
14. Erlyana E, Fisher D, Reynolds G, Jansen M. Medical service use among individuals receiving HIV prevention services in Los Angeles County. *J Health Hum Serv Adm*. 2014;36(4):498–498.
15. Green D, Goldbach J, Raymond H. Age cohort and health service use among gay men. *Am J Men's Health*. 2018;12(4): 1058–1067. doi:10.1177/1557988318774994.
16. Koester K, Collins S, Fuller S, Galindo G, Gibson S, Steward W. Sexual healthcare preferences among gay and bisexual men: a qualitative study in San Francisco, California. *PLoS One*. 2013;8(8):e71546. doi:10.1371/journal.pone.0071546.
17. Mckirnan D, Du Bois S, Alvy L, Jones K. Health care access and health behaviors among men who have sex with men: the cost of health disparities. *Health Educ Behav*. 2012;40(1):32–41. doi:10.1177/1090198111436340.
18. Uphold C, Mkanta W. Use of health care services among persons living with HIV infection: State of the science and future directions. *AIDS Patient Care Stud*. 2005;19(8):473–485.
19. Andersen R. *A Behavioral Model of Families' use of Health Services. Research Series No. 25*. Chicago: Center for Health Administration Studies, University of Chicago; 1968
20. Andersen R. Revisiting the behavioral model and access to medical care: does it matter? *J Health Soc Behav*. 1995;36(1):1–10. doi:10.2307/2137284.
21. Bradley EH, Mcgraw SA, Curry L, et al. Expanding the Andersen model: the role of psychosocial factors in long-term care use. *Health Serv Res*. 2002;37(5):1221–1242. doi:10.1111/1475-6773.01053.
22. Hirshfield S, Downing M, Horvath K, Swartz J, Chiasson M. Adapting Andersen's behavioral model of health service use to examine risk factors for hypertension among U.S. MSM. *Am J Men's Health*. 2018;12(4):788–797. doi:10.1177/1557988316644402.
23. Majaj L, Nassar M, De Allegri M. It's not easy to acknowledge that I'm ill: a qualitative investigation into the health seeking behavior of rural Palestinian women. *BMC Women Health*. 2013;13(1):26. doi:10.1186/1472-6874-13-26.
24. Mcclain Z, Hawkins L, Yehia B. Creating welcoming spaces for lesbian, gay, bisexual, and transgender (LGBT) patients: an evaluation of the healthcare environment. *J Homosexuality*. 2016;63(3):387–393. doi:10.1080/00918369.2016.1124694.
25. Ginsburg KR, Winn RJ, Rud BJ, Zhao H, Schwarz DF. How to reach sexual minority youth in the health care setting: the teens offer guidance. *J Adolesc Health*. 2002;31:407–416. doi:10.1016/S1054-139X(02)00419-6.
26. Petrovic K, Blank T. The Andersen –Newman Behavioral Model of Health Service Use as a conceptual basis for understanding

patient behavior within the patient–physician dyad: The influence of trust on adherence to statins in older people living with HIV and cardiovascular disease. *Cogent Psychol*. 2015;2(1). doi:10.1080/23311908.2015.1038894.

27. Patton MQ. *Qualitative Research and Evaluation Methods*. 3rd ed. Thousand Oaks, CA: Sage; 2002.
28. Yin RK. *Case Study Research and Applications: Design and Methods*. Thousand Oaks, CA: Sage; 2017.
29. Fredriksen GK. Despite disparities, most LGBT elders are aging well. *Aging Today*. 2014;35(3):1–3.
30. Wight R, Leblanc A, Meyer I, Harig F. Internalized gay ageism, mattering, and depressive symptoms among midlife and aging gay-identified men. *Soc Sci Med*. 2015;147:200–208. doi:10.1016/j.socscimed.2015.10.066.
31. Palma A, Lounsbury DW, Messer L, Quinlivan EB. Patterns of HIV service use and HIV viral suppression among patients treated in an academic infectious diseases clinic in North Carolina. *AIDS Behav*. 2015;19(4):694–703. doi:10.1007/s10461-014-0907-8.
32. Creswell JW, Creswell JW. *Qualitative Inquiry & Research Design: Choosing Among Five Approaches*. 2nd ed. Thousand Oaks, CA: Sage; 2007.
33. Guest G, Bunce A., Johnson L. How many interviews are enough? An experiment with data saturation and variability. *Field Meth*. 2006;18(1):59–82.
34. Morse J. Designing funded qualitative research. In: Denzin N, Lincoln Y, eds. *Handbook for Qualitative Research*. Thousand Oaks, CA: Sage; 1994:220–235.
35. Trotter R. Qualitative research sample design and sample size: resolving and unresolved issues and inferential imperatives. *Preven Med*. 2012;55(5):398–400. doi:10.1016/j.ypmed.2012.07.003.
36. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol*. 2006;3(2):77–101. doi:10.1191/1478088706qp063oa.
37. Clarke V, Braun V. Thematic analysis. *J Posit Psychol*. 2017;12(3):297–298. doi:10.1080/17439760.2016.1262613.
38. Swain J. *A Hybrid Approach to Thematic Analysis in Qualitative Research: Using a Practical Example*. London, United Kingdom: Sage Ltd; 2018.
39. Lincoln YS., Guba EG. *Naturalistic Inquiry*. Beverly Hills, CA: Sage; 1985.
40. Kihn L, Ihantola E. Approaches to validation and evaluation in qualitative studies of management accounting. *Qual ResAccount Manage*. 2015;12(3):230–255. doi:10.1108/QRAM-03-2013-0012.
41. Javadi M, Zarea M. Understanding thematic analysis and its pitfalls. *J Client Care*. 2016;1(1):33–39.
42. Ong AD, Bergeman CS, Boker SM. Resilience comes of age: defining features in later adulthood. *J Personal*. 2009;77(6):1777–1804. doi:10.1111/j.1467-6494.2009.00600.x.
43. Terrill A, Molton I, Ehde D, et al. Resilience, age, and perceived symptoms in persons with long-term physical disabilities. *J Health Psychol*. 2016;21(5):640–649. doi:10.1177/1359105314532973.
44. Hassani P, Izadi-Avanji FS, Rakhshan M, Majd HA. A phenomenological study on resilience of the elderly suffering from chronic disease: a qualitative study. *Psychol Res Behav Manag*. 2017;10:59–67. doi:10.2147/PRBM.S121336.
45. Dang BN, Westbrook RA, Njue SM, Giordano TP. Building trust and rapport early in the new doctor-patient relationship: a longitudinal qualitative study (report). *BMC Med Educ*. 2017;17(1):32. doi:10.1186/s12909-017-0868-5.
46. Ha JF, Longnecker N. Doctor-patient communication: a review. *Ochsner J*. 2010;10(1):38–43.
47. Bolderston A, Ralph S. Improving the health care experiences of lesbian, gay, bisexual and transgender patients. *Radiography*. 2016;22(3):e207–e211. doi:10.1016/j.radi.2016.04.011.
48. Streed C, Davis J. Improving clinical education and training on sexual and gender minority health. *Curr Sexual Health Report*. 2018;10(4):273–280. doi:org/10.1007/s11930-018-0185-y.
49. Thompson H, Coleman J, Kent P. LGBT medical education: first-year medical students' self-assessed knowledge and comfort with transgender and LGB populations. *Med Sci Educ*. 2018;28(4):693–697. doi:10.1007/s40670-018-0614-6.
50. White W, Brenman S, Paradis E, et al. Lesbian, gay, bisexual, and transgender patient care: medical students' preparedness and comfort. *Teach Learn Med*. 2015;27(3):254–263. doi:10.1080/10401334.2015.1044656.
51. LaVaccare S, Diamant AL, Friedman J, et al. Healthcare experiences of underrepresented lesbian and bisexual women: a focus group qualitative study. *Health Equity*. 2018;2(1):131–138. doi:10.1089/heq.2017.0041.
52. Traylor A, Subramanian U, Uratsu C, Mangione C, Selby J, Schmittdiel J. Patient race/ethnicity and patient–physician race/ethnicity concordance in the management of cardiovascular disease risk factors for patients with diabetes. *Diabetes Care*. 2010;33(3):520–525. doi:10.2337/dc09-0760.
53. Laveist T, Nuru Jeter A., Jones K. The association of doctor–patient race concordance with health services utilization. *J Public Health Policy*. 2003;24(3/4):312–323. doi:10.2307/3343378.
54. Eliason M, Dibble S, Robertson P. Lesbian, gay, bisexual, and transgender (LGBT) physicians' experiences in the workplace. *J Homosexuality*. 2011;58(10):1355–1371. doi:10.1080/00918369.2011.614902.
55. Lee RS, Melhado TV, Chacko KM, White KJ, Huebschmann AG, Crane LA. The dilemma of disclosure: patient perspectives on gay and lesbian providers. *J Gen Intern Med*. 2007;23:142–147.
56. Brennan-Ing M, Seidel L, Larson B, Karpiak SE. Social care networks and older LGBT adults: challenges for the future. *J Homosexuality*. 2013;61(1):21–52. doi:10.1080/00918369.2013.835235.
57. Earnshaw V, Lang S, Lippitt M, Jin H, Chaudoir S. HIV stigma and physical health symptoms: do social support, adaptive coping, and/or identity centrality act as resilience resources? *AIDS Behav*. 2015;19(1):41–49. doi:org/10.1007/s10461-014-0758-3.
58. Masini B, Barrett H. Social support as a predictor of psychological and physical well-being and lifestyle in lesbian, gay, and bisexual adults aged 50 and over. *J Gay Lesbian Soc Serv*. 2008;20(1-2):91–110. doi:10.1080/10538720802179013.