Implementation of Universal Chlamydia and Gonorrhea Screening for Adolescents in Pediatric Primary Care

Baylor University
LOUISE HERRINGTON SCHOOL OF NURSING

Amy Kirkendall, DNP, APRN, CPNP-PC, RNC-NIC
Faculty Advisor: Renea Powell, DNP, APRN, NNP-BC, CPNP-PC

Background

- Chlamydia (CT) and Gonorrhea (GC) are the 2 most reported sexually transmitted infections (STIs) and are the second and third most costly STIs to the United States healthcare system.
- Treatment of STIs costs the United States about $16 billion/year.
- Half of new STIs in the United States have been found in individuals between the ages of 15 and 24.
- STIs that remain untreated can result in long-term health consequences such as pelvic inflammatory disease.
- The American Academy of Pediatrics recommends testing adolescents for STIs if there is a positive risk assessment; however, this requires obtaining an accurate history from the adolescent.

Literature Review

- Workflow Standardization
  - Upon arrival, qualifying patients for screening would receive specimen cups prior to patient rooming. Order would be placed upon receiving consent then adolescent's phone number would be verified.
  - Variance in provider involvement can affect effectiveness of workflow interventions.
  - Scripts/ electronic prompts can be helpful for discussing screening with adolescents.
- Increased GC and CT Detection
  - Although rates of positive tests were not significantly different pre- and post-implementation, one study found positive test results from patients who denied being sexually active.
- Stakeholder Views
  - Providers:
    - Concerns about patient privacy arose when it comes to universal screening.
    - Various comfort levels when talking to teens about sexual health.
    - Lack of uniformity in estimating a teen's risk level exists due to provider biases.
  - Parents
    - View sexual health as a high-priority topic for their adolescent's health.
  - Patients
    - Comfort with provider affects how they talk about sensitive topics.
    - Teens 14-17 years old are less likely to disclose being sexually active to provider.

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Purpose

- QI Project
  - Increase testing rates of GC and CT in all adolescents 16 and older in a pediatric primary care clinic.
- Materials
  - Staff Inservice Presentation
  - Frequently asked questions handout for patients.
- Setting
  - Pediatric primary care clinic in the Denver-metro area.
  - No data on testing rates pre-implementation.
  - 90 day implementation period.

Methods

- Staff inservice provided to all office staff regarding STI testing for adolescents and proposed process change. Pre-and post-tests collected to determine evidence of learning.
- Process:
  - Adolescent patient checks in.
  - Medical assistant provides urine specimen cup to collect sample while waiting for provider.
  - Provider discusses GC and CT testing during well-visit and obtains consent for testing
  - Sample sent to lab upon collection.
  - If positive: notify patient and prescribe appropriate treatment and discuss recommended follow-up.
  - If negative, communicate results to patient if patient wanted to be notified of negative results.
- Plan-Do-Study-Act (PDSA) Cycles
  - #1: process as above
  - #2: handout incorporated to discuss reasons behind testing.

Outcomes

- Clinic staff showed statistically significant evidence of learning between pre- and post-tests given during inservice presentation (p= 0.005).
- 56 adolescent patients seen for well-child checks and 25 of those patients were tested for GC and CT.
  - 6 patients declined testing and others were not tested for unknown reasons.
- 1 patient tested positive for CT during the implementation period and was notified within 24 hours of the clinic receiving positive results.
- No statistically significant difference between testing rates between PDSA cycles.

Limitations

- Limited Sample Size
  - Implementation during the spring semester. More sick visits and limited well visits, especially in the adolescent population.
- No pre-implementation data to compare implementation data to.
- Barriers not thoroughly documented.
  - Providers did share perceived barriers.
    - Patient declination
    - Self-pay vs having medical insurance.
    - Providers' perceived comfort levels with discussing the topic with adolescent patients.

Implications for Practice

- Professional development for providers may be helpful with increasing comfort levels with discussing sexual health with teenagers.
- Building rapport with adolescent patients is key, whether or not universal STI screening is implemented within a clinic.

References and Additional Materials

Scan for references

Scan for materials used and additional data analysis