Addressing Aboriginal and Torres trait Islander Population Incidence of Sexually transmitted infections – Exploring a successful Aboriginal Health Service Approach

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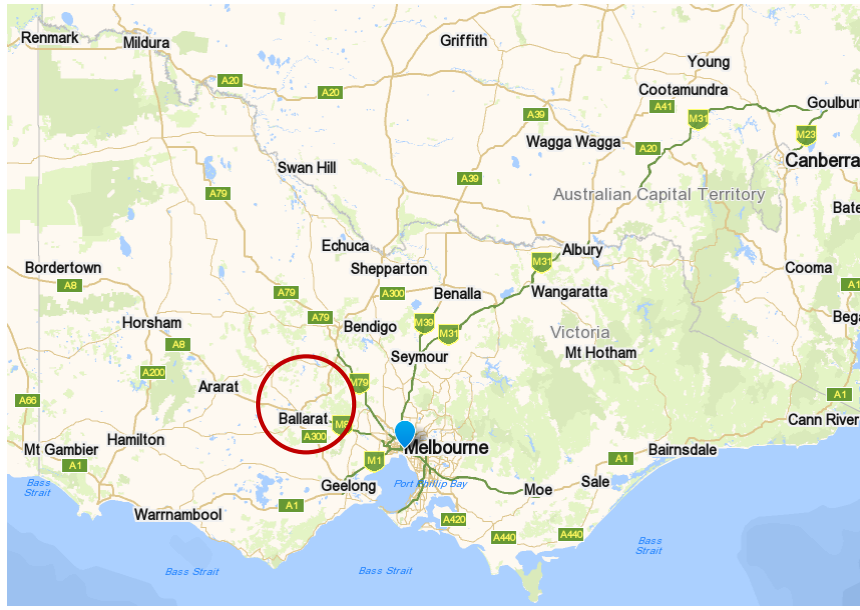
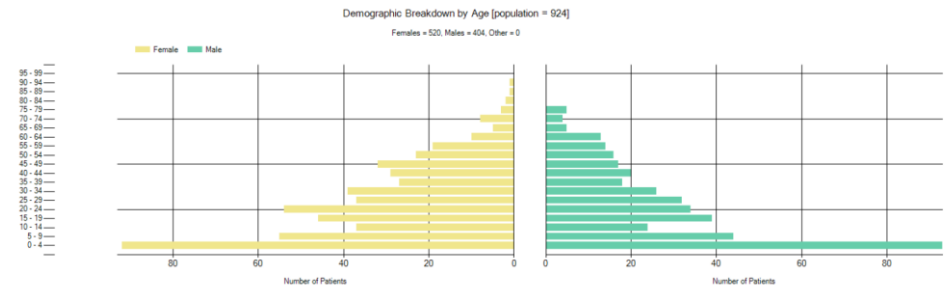
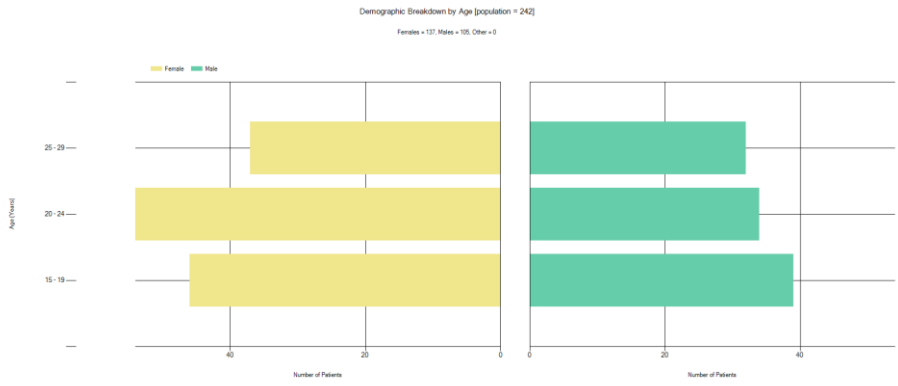


Aboriginal and Torres Strait Islander demographics at the clinic October 2017



Aboriginal and Torres Strait Islander demographics at the clinic August 2017

Aboriginal & Torres Strait Islander 15–29 years at the clinic 30 June 2017



ATSI health assessments

BADAC completed 385 Annual Health Checks and over 1000 in the past three years.

Year	Number of Health Checks completed
2014/15	327
2015/16	314
2016/17	385
Total	**1026**

Number of Annual Health Checks completed in last three years

The ATSI health check had always included sexual history and STI risk questions

In late 2014 the clinic team had a sense that we were testing for Chlamydia and Gonorrhoea quite well

So we checked the PCS Clinic Audit tool and what we found at the time was:

- That only positive active diagnosis for chlamydia, N. Gonorrhoea, HIV and syphillis can be identified
- There was no way to see number of tests/screens undertaken

We reviewed our follow up process for positive active diagnoses

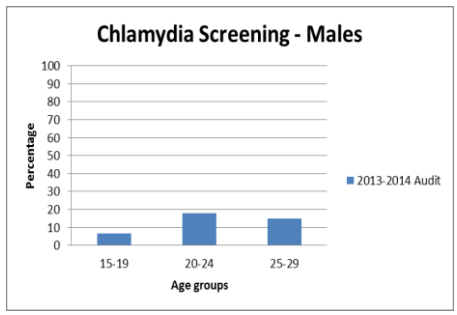
What were that challenges in finding out more?

In October 2014 a file audit for 130 males and 126 females was undertaken

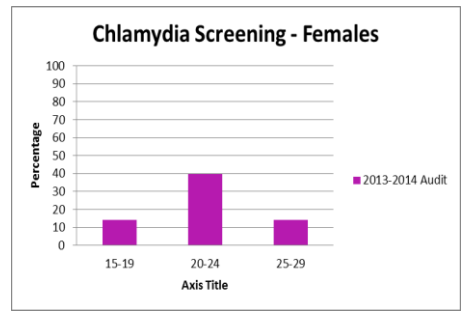
What did we want to know

- STI test ever?
- STI test in last year?
- The relationship between health checks & STI screening
- How well were we following up of positive STI

Chlamydia screening during the 2013-2014 audit
undertaken between 1 November 2013 and 31 October 2014

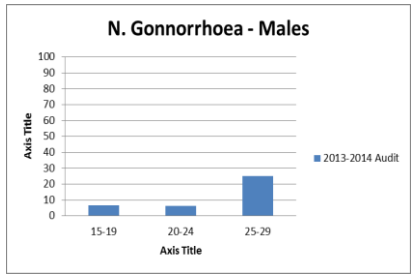


15-19 yrs – 44 males
20-24 yrs – 39 males
25-29 yrs – 20 males



15-19 yrs – 50 females
20-24 yrs – 48 females
25-29 yrs – 28 females

Gonorrhoea screening during 2013-2014 audit



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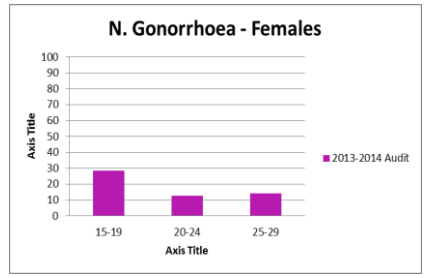


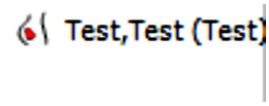
15-19 yrs – 50 females
20-24 yrs – 48 females
25-29 yrs – 28 females

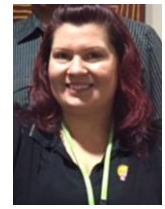
What did we learn

- Not every health check resulted in a Chlamydia or Gonorrhoea screen
- Was this due to offering an STI screen after discussing sexually active as part of the assessment?
- The clinic adopted the “whole of clinic” recommendation to invite all 15-29 ages to screen whatever the reason they were coming to the clinic
- Carefully worded “scripts” were developed and used to engage everyone in the eligible screening age group
- **ALL** team members were engaged
- Whilst we didn’t take a full sexual history at that point, the consent for the test and the prevention messages open a sexual health conversation that would not have happened otherwise

Identifying the screening population without PenCat

- Originally an individual file audit of the 250 eligible community was required to a manual hard copy list of current clients 15 -29 years
- The master hard copy list was colour coded to identify those previously screened and positive results for follow up
- The AHW Jade – identified these unscreened clients booked to attend the clinic the next day with a symbol and requested STI screen in "warnings" box





- **THIS WAS ERROR PRONE AND REQUIRED MANY FILE AUDITS UNTIL: PenCS CAT version 4.0 arrived**

Identifying the screening population with PenCS CAT tool

Now the eligible ATSI population aged 15 – 29 years were identified:

- Those screened for Chlamydia, Gonorrhoea in the last 12 months
- Those screened for Chlamydia, Gonorrhoea every but greater than 12 months
- Those never screened

Clinical Quality Coordinator triaged STI results and coordinated the team to provide follow up into the system

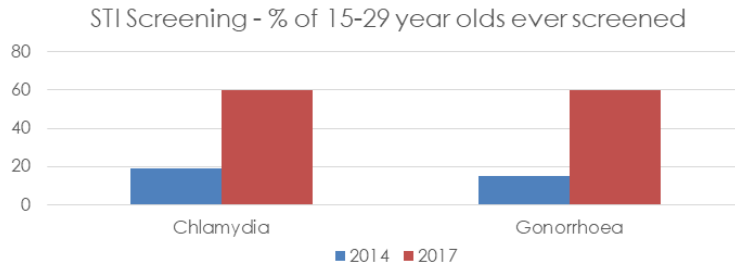
Our systems based approach was refiled and evaluated at monthly meeting

It was a whole of clinic team approach to increase STI screening

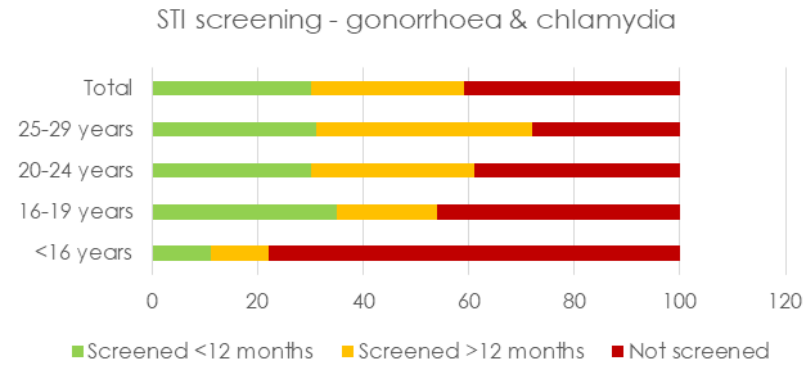
Monitoring screening

- The Koolin Balit, Working Together for Health Project being undertaken at the BADAC clinic provided an opportunity to recommend improvements to PCS Clinical Audit Tool to record STI screening tests
- When the 4.0 PenCS CAT was updated not only was chlamydia and gonorrhoea screening reported but it also identified health assessment and pregnancy in the report
- From this time the STI screening process we undertook became simpler, achievable and replicable
- We could then focus on the other key ingredient to success building and maintaining trusted relationships with the ATSI community

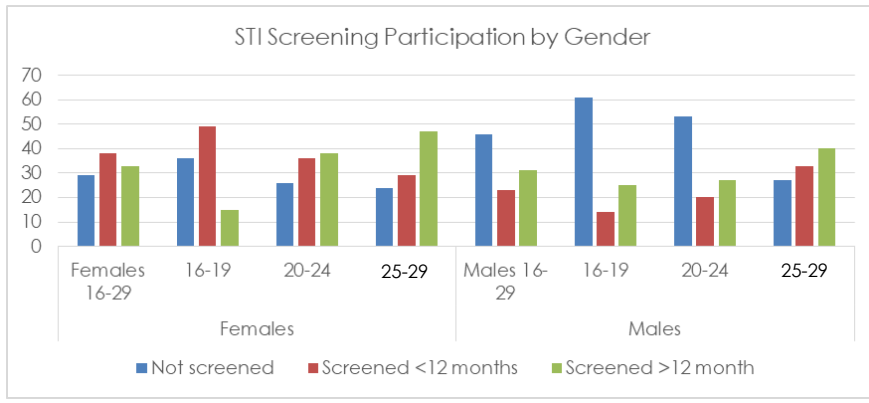
Comparing current participation in STI screening rates from 2013-14 audit there has been a significant increase to 30 June 2017.



Baarlinjan Medical Clinic Screening over the last 12 months, more than 12 months or not screened



Aboriginal and Torres Strait Islander males versus females 2016 to 2017



What did we learn?

That using opportunistic STI screening worked as we have achieved 30% plus screening in the last three years since the original audit

When a client was offered screening it opened a conversation about STIs that wouldn't have happened.

We couldn't rely on 15-29 age group to access a health check to receive STI screening:
As in the 2016 – 2017 years
- ✖ 20/126 females had a health assessment
- ✖ 19 /103 males had a health assessment

Chlamydia and gonorrhoea incidence

?

Sadly monitoring the incidence of chlamydia and gonorrhoea was unreliable as doctors had not been coding correctly in the scripted text in the medical software

Partly this is because there are a multiple numbers of issues regularly dealt with in a single consult so many conditions to code

Ongoing education of coding priorities is important

Incorporating learnings into regular clinic practice

- The STI group at the clinic meets monthly to review the STI screening work and to continue to improve processes. We have a continuous quality improvement process.
- Documenting our quality improvement cycles is important for clinic legacy but also for clinic accreditation

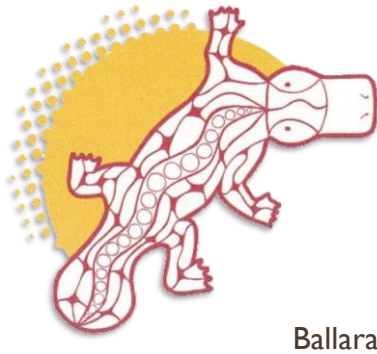
Considerations for future work

- What other STIs should we been screening for?
- We are beginning to build our work with Hepatitus C clients and using a patient centered approach to ensure they can access treatment.

Where to from here – we need to:

Promote more condom use and routine use of contraception

Baarlinjan clinical nurses and Aboriginal Health workers - that make it all happen



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