Prevention and management of chlamydial and gonococcal infections are priorities for women’s health. Research demonstrates that as many as 20% of females acquire chlamydia (CT) or gonorrhea (GC) again within six months after their initial positive test and treatment. Repeat infection is associated with an increased risk of reproductive complications, including a four-fold risk of pelvic inflammatory disease and a two-fold risk of ectopic pregnancy, which are in turn associated with a higher risk of infertility.

Therefore, as outlined in the 2010 STD Treatment Guidelines, retesting is a “priority for providers.” CDC recommends that women and men who have been evaluated and treated for N. gonorrhoeae and C. trachomatis infections should be retested approximately three months after treatment. If retesting at 3 months is not possible, CDC recommends that clinicians retest whenever persons next present for medical care in the 12 months following initial treatment, regardless of whether they believe that their sex partners were treated.

At the 2011 National Title X Grantee Meeting, Holly Howard presented a talk entitled “Developing a Multi-Pronged Quality Improvement Strategy to Increase Chlamydia trachomatis (CT) Retesting Rates in the California Family Planning Setting: Building a Framework for Success.” The talk described the InTOUCH Study, a Family Planning Service Delivery Improvement study funded by the U.S. Department of Health and Human Services’ Office of Population Affairs and developed and implemented by the California Department of Public Health STD Control Branch and California Family Health Council, Inc. The study is designed to evaluate whether clinic and client interventions that improve logistics, services and options related to CT/GC retesting are effective in increasing retesting rates in California family planning clinics. Current study sites include six Planned Parenthood clinics in northern California, the Central Valley and Los Angeles.

To develop successful interventions that would effectively target the underlying reasons for low retesting rates, InTOUCH researchers implemented a four-pronged strategy: 1) obtained agency buy-in to institute retesting as a high priority clinical service; 2) introduced clinic-level interventions—including chart prompts, protocols to allow specimen collection by all levels of clinic staff, retesting risk assessment procedures, and drop-in STD testing visits—to reduce missed opportunities for retesting; 3) delivered a 1.5-hour training for all clinic staff on how to provide comprehensive counseling for patients who have been evaluated and treated for CT/GC; and 4) introduced client-level interventions—including new fact sheets for patients who test positive for CT/GC, flip cards with specific messages about the importance of CT/GC retesting and a place to indicate a future appointment date, the option for patients to receive retesting reminder messages via automated text or email message or via self-addressed postcard, and the option for patients to choose to take their retest at home using a mailed-in self-
collection test kit.

While the study is still in progress, InTOUCH researchers recently analyzed preliminary data to assess the impact of the clinic-level interventions to date. These results, presented by Holly Howard at the 2012 National STD Prevention Conference, compared post-study patient cohorts to historical cohorts in each clinic and agency and specifically evaluated the effect of automated electronic chart prompts or “pop-ups” that identified to clinic staff when presenting patients were due for a retest. Retesting rates among returning patients increased in all clinics, and significantly from an average of 70% in the historical cohort to 86% post-study across all sites, with the most dramatic results seen in those clinics with the lowest pre-intervention retesting rates.

The InTOUCH Study is scheduled to conclude at the end of 2012. Final study results will measure the impact of the patient-level interventions in improving patient return rates, as well as summarize qualitative results from staff and patient interviews that aim to assess the acceptability of and satisfaction with study strategies and to gather information about any further clinic- or patient-level barriers to retesting that may be contributing to low retesting rates.

Further resources and examples of feasible steps to take to improve both retesting rates and partner services can be found in the California Infertility Prevention Project Collaborative’s recently published Best Practices for the Prevention and Early Detection of Repeat Chlamydial and Gonococcal Infections: Effective Partner Treatment and Patient Retesting Strategies for Implementation in California Health Care Settings, on the California Department of Public Health, STD Control Branch website.

References

