Referring clinic turn-aways to GetCheckedOnline to increase capacity for timely STI/HIV testing


World STI & HIV Congress
September 13-16, 2015

Demand on STI clinic services

- Increasing demands on STI clinical services, coinciding with reductions in capacity and infrastructure
- Wait times for scheduled or drop-in appointments are a known barrier to testing
- Need for novel strategies to meet demand:
  - Streamline clinic flow:
    - Computer-assisted self-interviewing
  - Triage asymptomatic or low-risk patients:
    - Express specimen collection (including self-collection)

British Columbia is no exception

- Increasing rates of STI
- Closures of STI clinics in some regions
- STI clinics operated by the BC Centre for Disease Control (BCCDC):
  - Operating at maximum capacity
  - Increasing number of drop-in clients are turned away
- Pressures led to development of an online STI testing service as extension of BCCDC
- Could online testing be an option for drop-ins who are turned-away?

Purpose

- Assess the feasibility of referring STI clinic clients who drop-in but can’t be seen to the new online STI testing service
- Pilot program to establish proof-of-concept → incorporated into current clinical practice

Disclosure

No conflicts of interest to disclose

GetCheckedOnline (GCO)

- Testing for Chlamydia, gonorrhoea, syphilis, HIV & hepatitis C
- Integrated with current STI clinical practices at BCCDC
- For clients who are asymptomatic and not contacts
- Six specimen collection sites in Vancouver
- Launched September 2014

Getcheckedonline.com
GetCheckedOnline access points

- 2 ways to access testing:
  - email invitation to STI clinic clients that sign-up during clinic visit
  - access code which can be used to create an account

- Unique access codes created for different types of promotion (e.g., print or online) → can track uptake across channels

Piloted in three clinic settings

<table>
<thead>
<tr>
<th></th>
<th>Provincial STI Clinic</th>
<th>Outreach STI Clinic</th>
<th>Health Initiative for Men Clinic (HIM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual volume</td>
<td>&gt;10,000 clients</td>
<td>&gt;9,000 clients</td>
<td>&gt;5000 clients</td>
</tr>
<tr>
<td>Demographics</td>
<td>60% Male</td>
<td>80% Male</td>
<td>99% Male</td>
</tr>
<tr>
<td>Type of visits</td>
<td>Appointments</td>
<td>Drop-in</td>
<td>Appointments</td>
</tr>
<tr>
<td>Referral to GCO</td>
<td>Brochure Code over phone</td>
<td>Brochure Code over phone</td>
<td>Brochure Code over phone</td>
</tr>
<tr>
<td>How made aware</td>
<td>Active (clerical, nursing staff)</td>
<td>Passive (displayed in waiting room)</td>
<td>Active (staff and volunteers)</td>
</tr>
<tr>
<td>Referrals documented</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Methods

- Data sources:
  - Referral logs (Provincial clinic only)
  - GCO program data, by access code (all pilot clinics)
  - Common electronic medical record (total tests)

- Analysis:
  - March 1 to July 31, 2015 (five months)
  - Creation of accounts and requisitions, testing and results
  - Comparison of uptake at Provincial clinic (clinic vs phone) and across clinics
  - Fisher’s exact test or Chi-square test, p<0.05

Trends in uptake

Referrals to GCO – Provincial STI Clinic

<table>
<thead>
<tr>
<th></th>
<th>In Clinic</th>
<th>By Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total turned away</td>
<td>641</td>
<td>741</td>
</tr>
<tr>
<td>Turned away no appt</td>
<td>560</td>
<td>516</td>
</tr>
<tr>
<td>Access code provided</td>
<td>37</td>
<td>108</td>
</tr>
<tr>
<td>GCO accounts created</td>
<td>12</td>
<td>80</td>
</tr>
<tr>
<td>Completed testing</td>
<td>10</td>
<td>62</td>
</tr>
<tr>
<td>Positive results</td>
<td>87%</td>
<td>74%</td>
</tr>
</tbody>
</table>

* p<0.0001, compared to in clinic
### Referrals to GCO – By clinic

<table>
<thead>
<tr>
<th></th>
<th>Provincial Clinic</th>
<th>Outreach &amp; HIM Clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>GCO accounts created</td>
<td>92</td>
<td>37</td>
</tr>
<tr>
<td>78%</td>
<td></td>
<td>* p&lt;0.001, compared to provincial clinic</td>
</tr>
<tr>
<td>Completed testing</td>
<td>72</td>
<td>7</td>
</tr>
<tr>
<td>3%</td>
<td></td>
<td>0%</td>
</tr>
<tr>
<td>Positive results</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Clients tested in clinic</td>
<td>2,413</td>
<td>2,949</td>
</tr>
<tr>
<td>Total tested</td>
<td>2,485</td>
<td>2,956</td>
</tr>
<tr>
<td>Increased capacity</td>
<td>2.9%</td>
<td>0.2% *</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* p&lt;0.001, compared to provincial clinic</td>
</tr>
</tbody>
</table>

### Summary – Key findings

- Referring to GCO was feasible and led to new STI diagnoses – proof of concept established!
- Clients provided access code over phone were more likely to create accounts than drop-ins turned away
- Lower use of access codes / completion of testing by clients in outreach/HIM clinics:
  - Passive versus active referral;
  - Prefer to wait or return another time (satisfied with services)
- Small increase in capacity at the provincial clinic

### Limitations & next steps

- Operational proof of concept only:
  - Add-on to usual operations, relied on existing procedures
  - Generic codes, not able to link to specific clinic clients in EMR
- Do not know whether intervention led to earlier diagnosis:
  - Time from access code given to completed testing
  - Comparison to other turn-aways who booked appointments
- Promising results and more rigorous evaluation needed:
  - Consistent offer of referral codes
  - Unique codes linked to client records and testing history in EMR
  - Client survey of turn-aways
  - Compare characteristics of turn-aways to other clients
  - Controlled study designs

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