

11-30-2016

Exploring the Feasibility of Incorporating Sexual Education into Routine Adolescent Office Visits

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Recommended Citation

Rankin, Holly A.; LoSasso, MD, Alisa; and Schwartz, MD, Beth I., "Exploring the Feasibility of Incorporating Sexual Education into Routine Adolescent Office Visits" (2016). *CwiC Posters*. 24.

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Exploring the Feasibility of Incorporating Sexual Education into Routine Adolescent Office Visits

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Abstract

Preventative sexual education can reduce the negative health outcomes of sexual behavior in adolescent populations.¹ **The objective of this pilot study was to determine if sexual education can be delivered as a scripted five-minute module during a routine adolescent office visit in a manner that is non-disruptive of clinic flow and acceptable to both patients and providers.**

- 85% of providers reported the intervention did not interrupt clinic flow
- 86% of patients reported the intervention to be appropriate and 92% of providers were satisfied overall with the intervention

These pilot data highlight that the incorporation of brief scripted sexual education into routine adolescent preventative office visits is both feasible and acceptable to patients and providers.

Introduction

The CDC reports around 20 million new cases of sexually transmitted infections (STIs) each year in the United States with around half of these in young people between the ages of 15-24.²

As compared to American counterparts, Philadelphia County 10-14 year olds are:

- 5.3x as likely to have Chlamydia
- 4x as likely to have Gonorrhea³

Untreated STIs can lead to infertility, ectopic pregnancy, pelvic inflammatory disease, chronic pelvic pain and death.

Methods

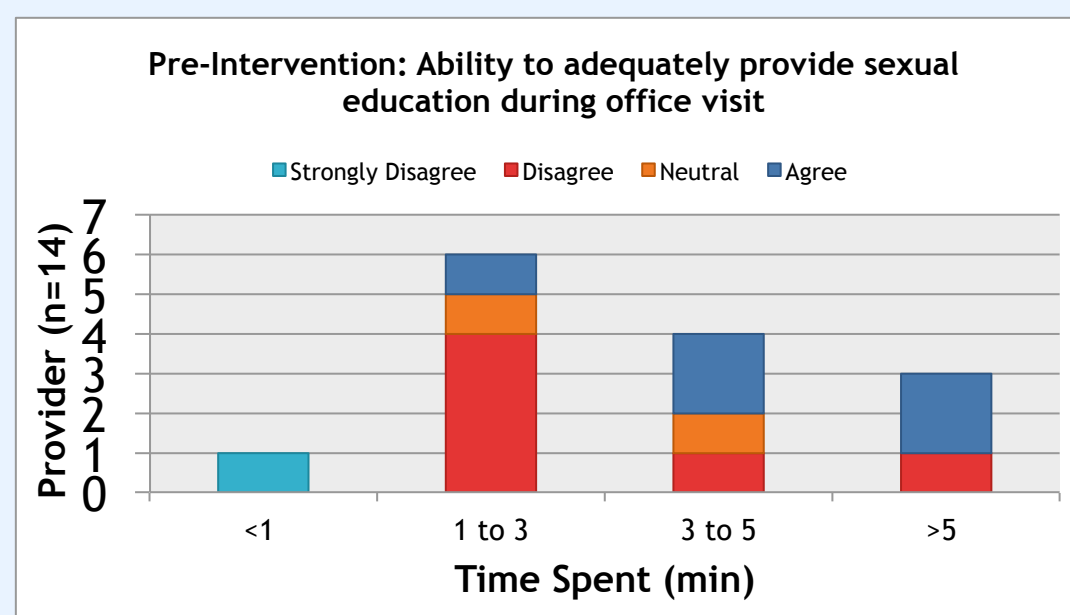
Eligible subjects were English-speaking 12-15 year old male and female patients presenting for routine preventative visits at a single urban tertiary care hospital outpatient pediatric practice. Providers included were all practice physicians and nurse practitioners who see patients for routine adolescent preventative visits.

A five-minute scripted **sexual education module defining sexual intercourse, associated risks of pregnancy and STIs, ways to reduce risks and recommendations for annual STI screening once sexually active** was given by a medical student to eligible patients prior to being seen by a provider in the examination room at the time of a routine physical.

Likert scale surveys assessed baseline provider sexual education counseling, and post-intervention patient and provider thoughts on the intervention's timing and acceptability.

Results

Fourteen providers completed the pre-intervention survey. All providers reported including sexual education in their routine adolescent preventative office visits and 86% cited time limitations as a barrier to providing sexual education.

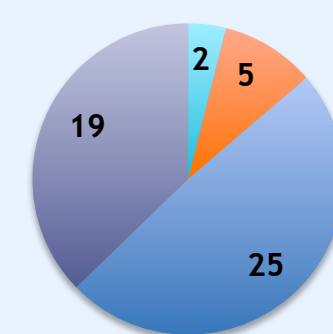


Provider ability to provide sexual education during office visit by self-reported amount of time.

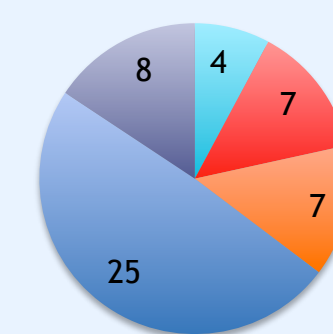
72 eligible patients were approached, 51 (71%) patients consented to participation and completed the study, and 21 (29%) patients declined to participate.

Characteristic	Consenting N (%)	Declining N (%)
Gender		
Male	23 (45)	9 (53)
Female	28 (55)	8 (47)
Age		
12	6 (12)	5 (29)
13	11 (22)	2 (12)
14	21 (41)	6 (35)
15	13 (25)	4 (24)
Race		
Black/African American	32 (62.7)	
White	11 (21.6)	
Asian/Pacific Islander	3 (5.9)	
Other/Mixed	5 (9.8)	

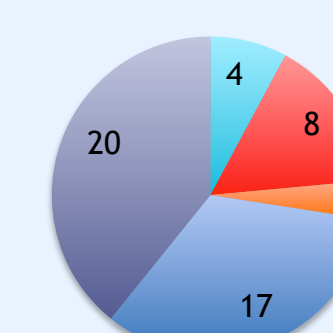
I think it is appropriate to discuss sexual health education during my doctor's visit.



I have heard this information from a doctor before.

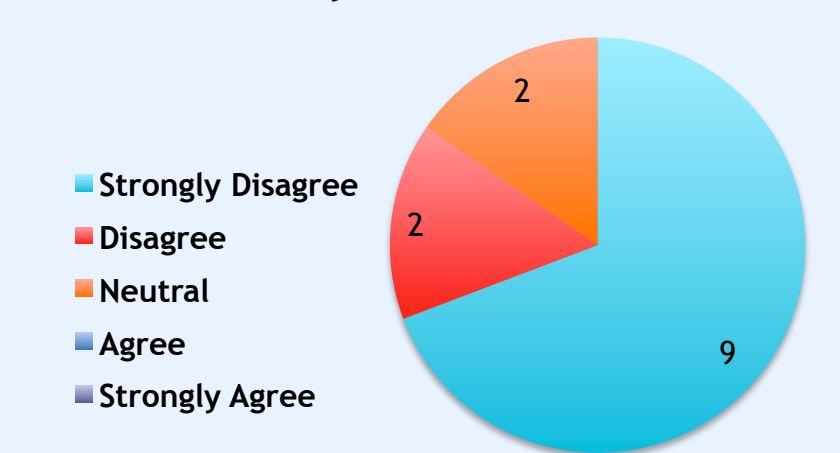


I learned new information today.

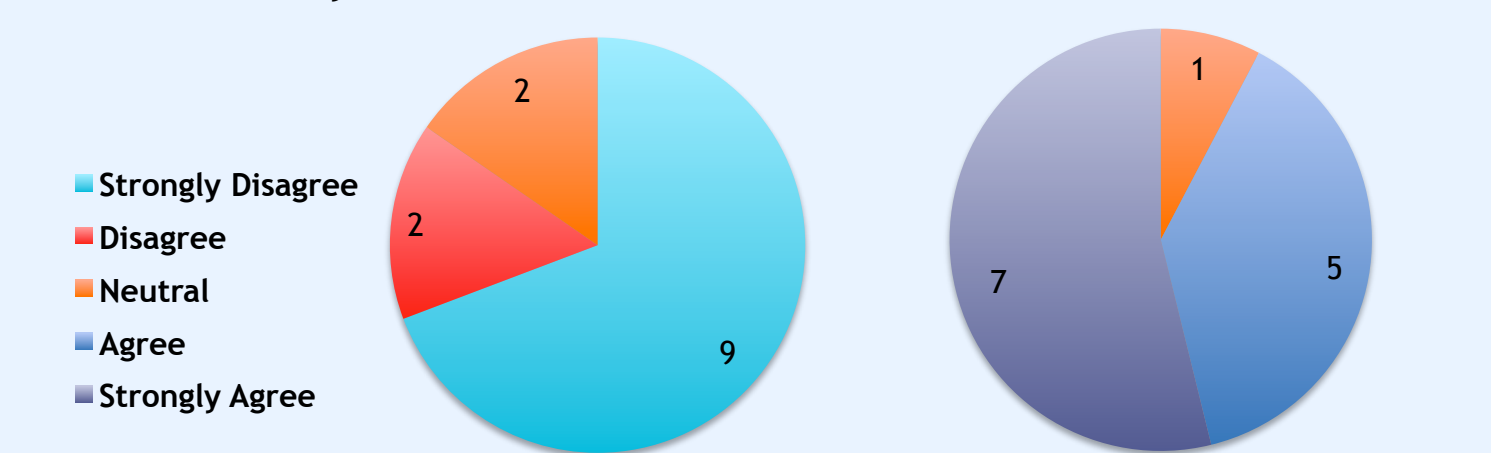


After the intervention period, thirteen of the initially surveyed providers were resurveyed. Eighty-five percent of providers disagreed or strongly disagreed that the intervention interrupted their clinic work flow. Seventy-seven percent of providers agreed or strongly agreed that the intervention was useful and 92% agreed or strongly agreed to being satisfied with the intervention.

The intervention interrupted my clinic work flow.



Overall, I am satisfied with the intervention.



CONCLUSION

These pilot data suggest that it is feasible to incorporate scripted sexual education into routine preventative office visits in a way that does not interrupt clinic flow and is considered acceptable to patients and providers.

The sexual education all providers reported including in their routine adolescent care was corroborated, with the majority of patients reporting hearing the intervention's information from a provider before. Despite this, the majority of patients also agreed to learning new information from the intervention.

The intervention's timing was well tolerated by providers, with the majority reporting that the intervention did not interrupt clinic flow. In terms of acceptability, the majority of patients felt the intervention to be appropriate and the majority of providers were satisfied with the intervention.

We recommend future incorporation of this module into routine clinical practice and study of the intervention's outcomes on STI testing and STI rates.

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