

ORIGINAL RESEARCH ARTICLE

Effects of a change from an appointment service to a walk-in triage service at a sexual health centre

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Summary: A walk-in triage system (WITS) was introduced at Melbourne Sexual Health Centre in August 2001 as a result of the perceived need to increase access to the clinic for clients requiring immediate assessment. An audit of this alteration to clinic operation resulted in a significant increase in the number of new clients attending the clinic who were younger and less likely to report using condoms, substantial increases in the number of investigations ordered for bacterial sexually transmitted infections (STIs) and an increase in the detection of genital herpes and chlamydia. There are a number of possible explanations for these changes other than the change to clinic operation but these are less likely causes for the observed changes. Our findings should complement the other reasons to adopt a WITS system, such as improving access for those most in need and vital to reach if STI rates are to fall.

Keywords: access, walk-in clinics, appointments, sexually transmitted infections, genitourinary medicine

Introduction

Many developed countries including Australia and the UK are experiencing very substantial increases in bacterial sexually transmitted infections (STIs) such as gonorrhoea and chlamydia^{1,2}. Early diagnosis and treatment of these infections are key elements to their successful control and this requires, amongst other resources, an accessible health service³. One recent survey of UK genitourinary medicine (GUM) clinics found that 29% of clinics provided an appointment only service and overall the median waiting time for a clinic appointment was five to six working days⁴. Only 54% of clinics were able to see clients requiring urgent appointments within 24 hours⁴. Consequences of such a situation range from distress for both clients and health care providers at the clinic level to escalation of the diseases rates at the population level.

In an attempt to increase access to the service for clients who were symptomatic, contacts of known STIs or for some other reason required immediate assessment Melbourne Sexual Health Centre (MSHC) recently changed from a predominantly

appointment system to a walk-in triage system (WITS). This report describes the changes that occurred after adopting WITS.

Methods

Melbourne Sexual Health Centre is a free, confidential inner city sexual health centre comprising general STI and related specialist clinics. Prior to 6 August 2001 new clients waited one to two weeks for an appointment. Clients presenting requesting assessment on the day were accommodated during already full appointment lists. From 6 August 2001, all new clients were triaged using a symptom based triage protocol administered by a registered nurse trained in sexual health. Following triage assessment clients were either seen in the clinic immediately or referred out of the clinic to an appropriate clinical service. Specialist clinics within the centre continued to operate on an appointment system.

Numbers of weekly general clinic sessions (49 before and 48 after 6 August 2001) and type (e.g. male or female) did not change. In June 2001 a standard casenote proforma was introduced to collect sexual behaviour data concerning the number of sexual partners and condom use over the three and 12 months prior to clinic presentation.

Changes in the number of investigations ordered for the common infections, chlamydia, gonorrhoea and herpes simplex virus were studied.

New clients presenting in the first five months of the WITS (6.8.01–31.12.01) and those presenting in the 12 months prior to the WITS (1.8.00–5.8.01) were compared on available demographic, behavioural and morbidity characteristics. The data were transferred into a study database, de-identified and χ^2 and *t*-tests used to compare variables using SPSS.

Results

There were 27 609 clinic attendances for 14 508 clients at MSHC during the study period (Table 1). New client numbers increased by 20% ($P=0.004$) per calendar month following WITS. The clinic attracted younger clients ($P=0.005$) who reported similar numbers of sexual partners ($P=0.61$) but were less likely to use condoms ($P=0.0001$). Overall the number of tests for genital herpes and chlamydia increased substantially as did the diagnoses of genital herpes ($P=0.001$) in both men and women and chlamydia in men ($P=0.04$).

Discussion

In our study the change from a predominantly appointment system to a walk-in triage system was associated with a significant increase in new clients who were younger and less likely to report using condoms. We also observed substantial increases in the number of investigations ordered for bacterial STIs and an increase in the detection of genital herpes in both sexes and chlamydia in men. These changes occurred with an alteration to clinic operation, rather than injection of additional staffing.

There are a number of possible explanations for the changes we observed that may not relate to the introduction of WITS. These include a change in the community prevalence of infection or external changes affecting clients accessing our clinic. We are not aware of any such external factors nor were there other changes to the centre during this time. It seems most likely that the changes in our clinic operation led to the changes we observed. However, it would be difficult to demonstrate this in a rigorous study. Such a study would need to randomize different sexual health centres to such

Table 1. Changes to the numbers and characteristics of clients, ordering of tests and detection of bacterial STIs following the adoption of WITS at MSHC

Variable	<i>n</i>	Appointment system*	WITS*	<i>P</i> value**
Clinic visits				
Number	27 609	19055	8554	
Number per calendar month*		1588	1711	0.12
Total client numbers	14 508	9620	4888	
New clients				
Number	6790	4531	2259	
Number per calendar month*		378	452	0.004
Men (%)		2000 (44)	983 (44)	0.62
Characteristics of new clients				
Age (yrs) (median+range)	6790	29.0 (14–83)	28.0 (14–90)	0.005
Number ≥ 2 opposite sex partners in three months [no. (%)]**	2380	143 (25)	429 (24)	0.61
Proportion using 'condoms always' [no. (%)]#	1846	149 (31)	290 (21)	0.0001
Total no. tests and diagnoses				
Chlamydia				
Total number of tests	11 178	7369	3809	
Mean number of tests/month*		614	762	0.001
Mean number of positive/month*†		23	29	0.10
% positive		3.6%	3.8%	0.63
Gonorrhoea				
Total number of tests	9884	6802	3082	
Mean number of tests/month*		567	616	0.13
Mean number of positive/month*		8	9	0.72
% positive		1.4%	1.1%	0.22
HSV 1 or 2				
total number of tests	1261	810	451	
Mean number of tests/month*		68	90	0.001
Mean number of positive/month*		16	26	0.001
% positive		24%	28%	0.08

*Appointment system analysed 1.8.00–5.8.01 (August 2001 excluded from analysis, therefore 12 calendar months). WITS analysed 6.8.01–31.12.01 (August 2001 included in analysis, therefore five calendar months)

***P* values for χ^2 (categorical variables) and *t*-test (non-parametric equivalents)

† $P=0.04$ for tests in men and $P=0.21$ for tests in women

#Number of sexual partner data derived from the behaviour questionnaire administered from 1.6.01, after which 3086 new clients were seen. Data on number of sexual partners was therefore available for 77% of clients and data on condom use for 60% of clients
Categories of client reported condom use—never/sometimes (< 50%)/usually/always (> 50%)

a change and is unlikely to be feasible. Our findings should complement the other reasons to adopt a WITS system, such as improving access for those most in need and most important to reach if STI rates are to fall.

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