Variability in Sexual History Documentation in a Primary Care Electronic Health Record System

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We sought to evaluate sexual history documentation and corresponding *Chlamydia trachomatis* screening practices across a large pediatric primary care network in the context of patient and clinic characteristics. Demographic, chlamydia screening, and provider note data were collected via electronic health record and manual chart audit for females aged 15-19 years attending annual well-adolescent visits, from February 1 to 28, 2019. Inductive qualitative textual analysis evaluated sexual history documentation as informative (containing clear indication of patient as sexually active or not) or noninformative and identified documentation subtypes. We examined patient and clinic characteristics by sexual history documentation type (informative or noninformative) and chlamydia screening status and documentation subtypes across clinic types using chi-square and Fisher's exact tests. A multilevel logistic regression model considering clinic-specific random effects evaluated predictors of informative sexual history documentation. Chart notes were examined for 1,062 patients across 31 unique clinics. Only 34.7% of chart notes were found to have informative sexual history documentation. Older patients (odds ratio: 1.51, 95% confidence interval: 0.99-2.31) and patients seen at clinics receiving U.S. Department of Health and Human Services Title-X funding (odds ratio: 11.05, 95% confidence interval: 1.34-90.86) had higher rates of informative documentation. The overall Chlamydia screening rate was 13.1%. Sexual history documentation varied widely across clinics, and the majority of chart notes were found to have noninformative documentation. Understanding and addressing barriers to informative sexual history documentation and comprehensive sexual health care is fundamental to improve adolescent sexual health outcomes, particularly given recently enacted federal electronic health record transparency policies.

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