

SNI Webinar: Chlamydia screening: Best practices and implementation strategies for primary care settings

Thursday, October 17, 2019
12:00 to 1pm

[Recording Link](#)

Agenda

Time	Topic	Lead(s)
5 min	Welcome, Logistics, QIP Measure & Introductions	Kristina Mody
45 min	Chlamydia screening: Best practices and implementation strategies for primary care settings	Holly Howard
10 min	Q&A	Holly Hunter Gatewood All
2 min	Wrap-up & Announcements <ul style="list-style-type: none">Upcoming eventsPost Event Survey	Kristina



Logistics



Please mute yourself! (We'll have to mute lines if there is background noise)



Please feel free to chime in for questions, and especially for the discussion



At any time, feel free to chat your question & we will read out



Webinar will be recorded and saved on
[SNI Link/Care Delivery](#)

QIP Context

- Member performance known after PY3 reports submitted in 12/15/20

Q-PC12 Chlamydia Screening in Women Ages 16-24

- Percentage of women ages 16 to 24 who were identified as sexually active and who had at least one test for chlamydia during the measurement year
- Nuances for QIP:
 - Patient must have had claim/encounter OR pharmacy data indicating sexual activity during measurement period
 - DPH/MCP Data exchange essential for both denominator and numerator

Intros



Holly Howard, MPH

Director, National STD Quality Improvement Center

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Chlamydia screening: Best practices and implementation strategies for primary care settings

I have no disclosures.

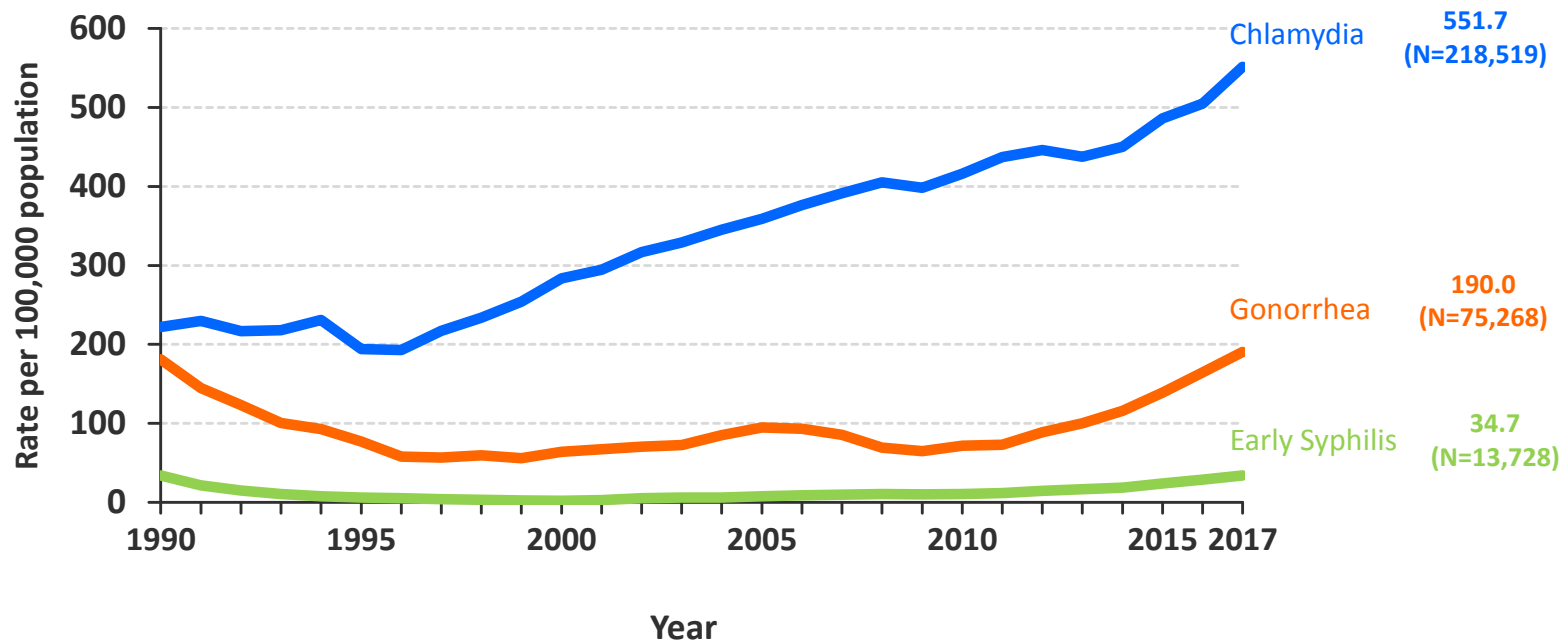
Today's Objectives

By the end of the webinar, you will be able to:

- Describe the **current rates and trends** of chlamydia infections and screening in CA
- Explain **CDC's** screening, treatment, and management **recommendations**
- Describe evidence-based **implementation strategies** for increasing chlamydia screening
- Identify **tools and resources that are available to support primary care settings** in increasing screening

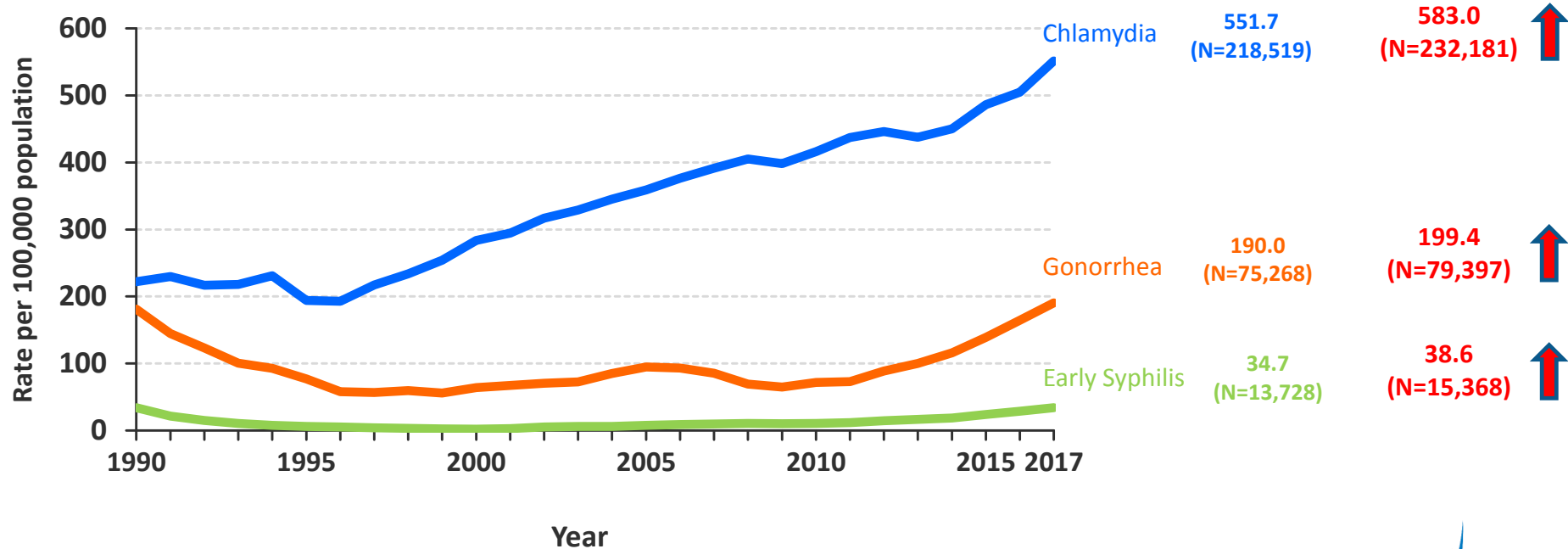
Chlamydia rates have been increasing for many years in California.

Chlamydia, Gonorrhea, and Early Syphilis
California Incidence Rates, 1990–2017



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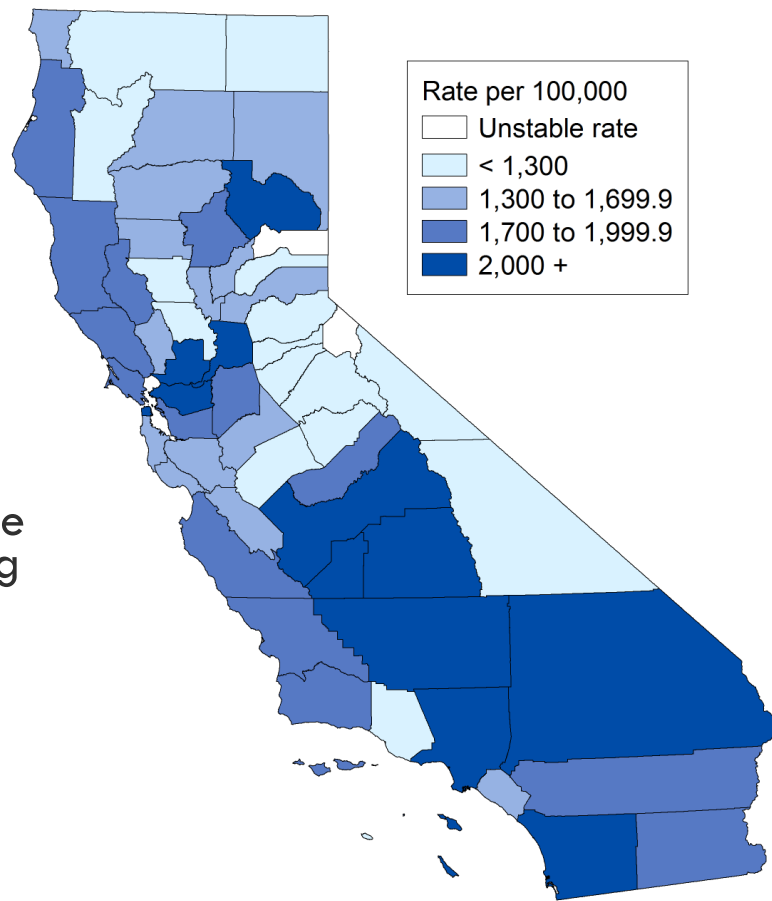
Chlamydia, Gonorrhea, and Early Syphilis
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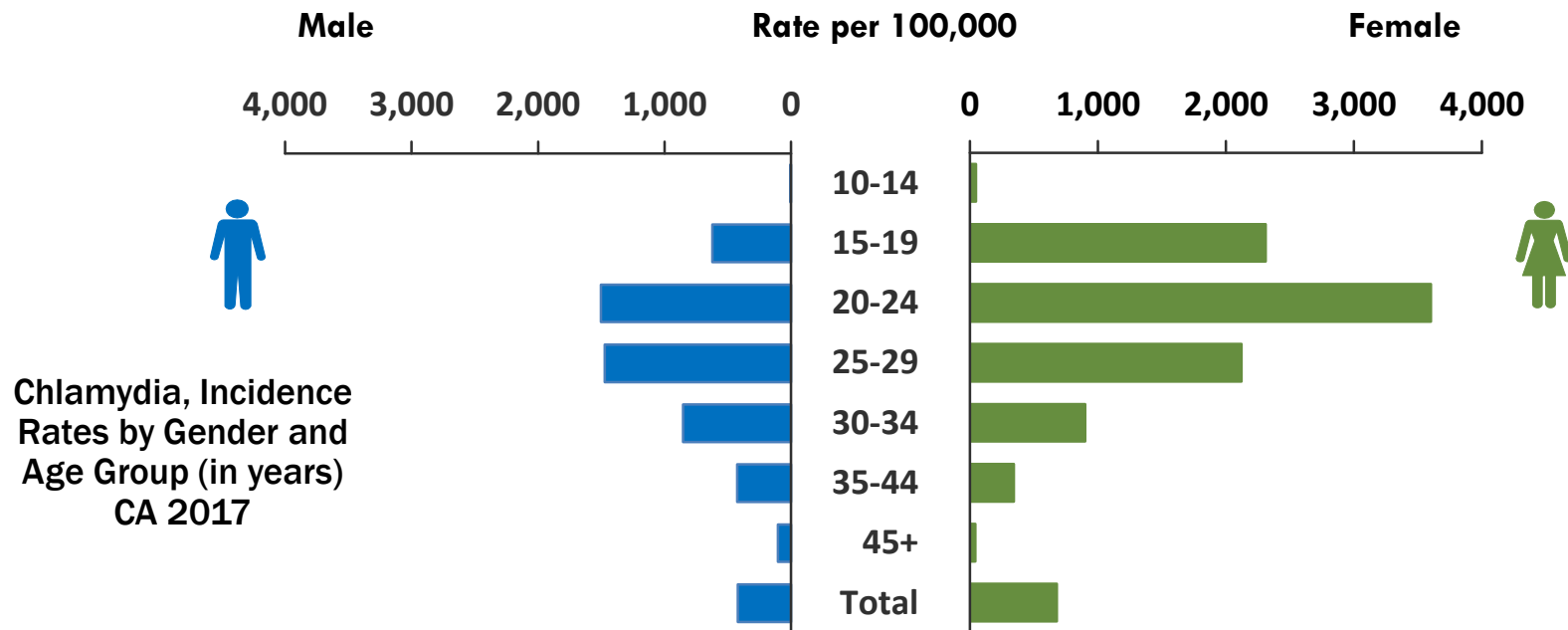
Provisional 2018 Data rev: 10/16/2018

Significant disparities in chlamydia rates exists across California counties

Chlamydia & Gonorrhea, Incidence Rates by County for Youth & Young Adults (ages 15-24 years), California, 2017

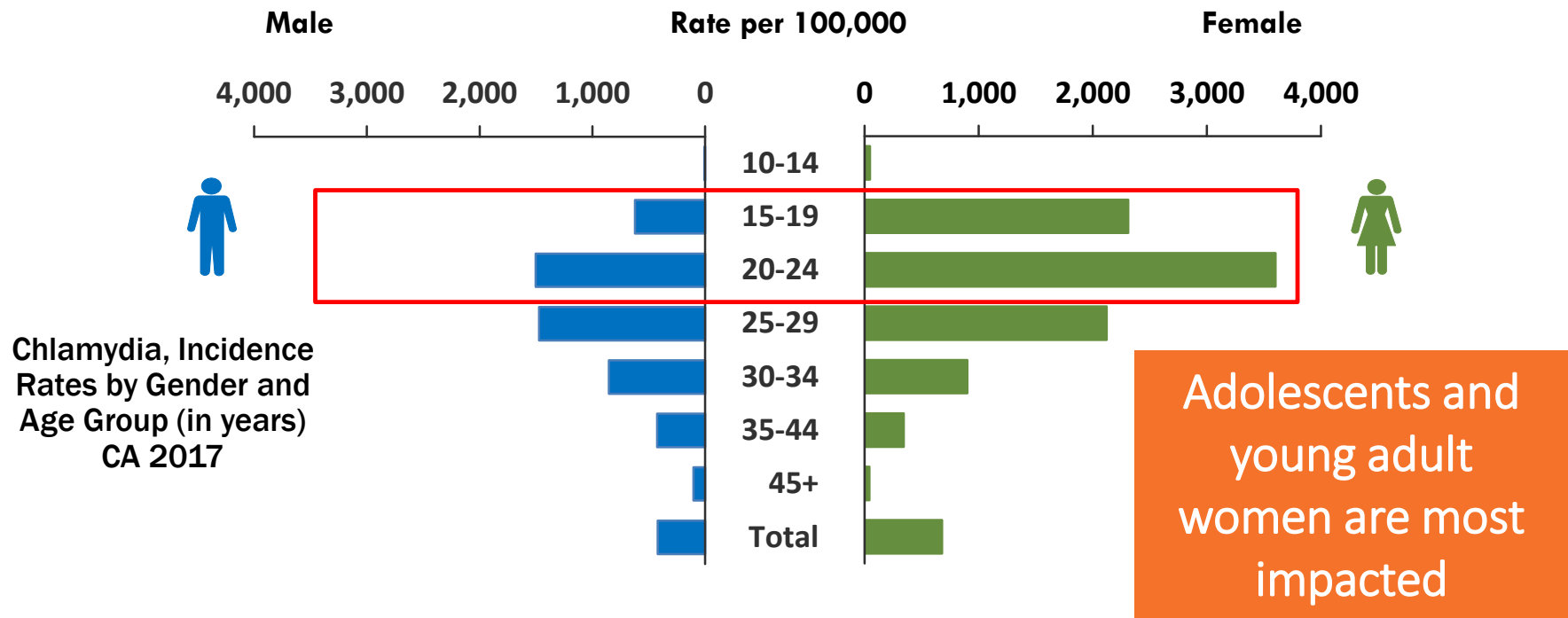


Adolescents and young adults are the populations most impacted by chlamydia



Note: Since this disease is often asymptomatic, reported cases may reflect chlamydial infections identified through screening programs offered primarily to women.

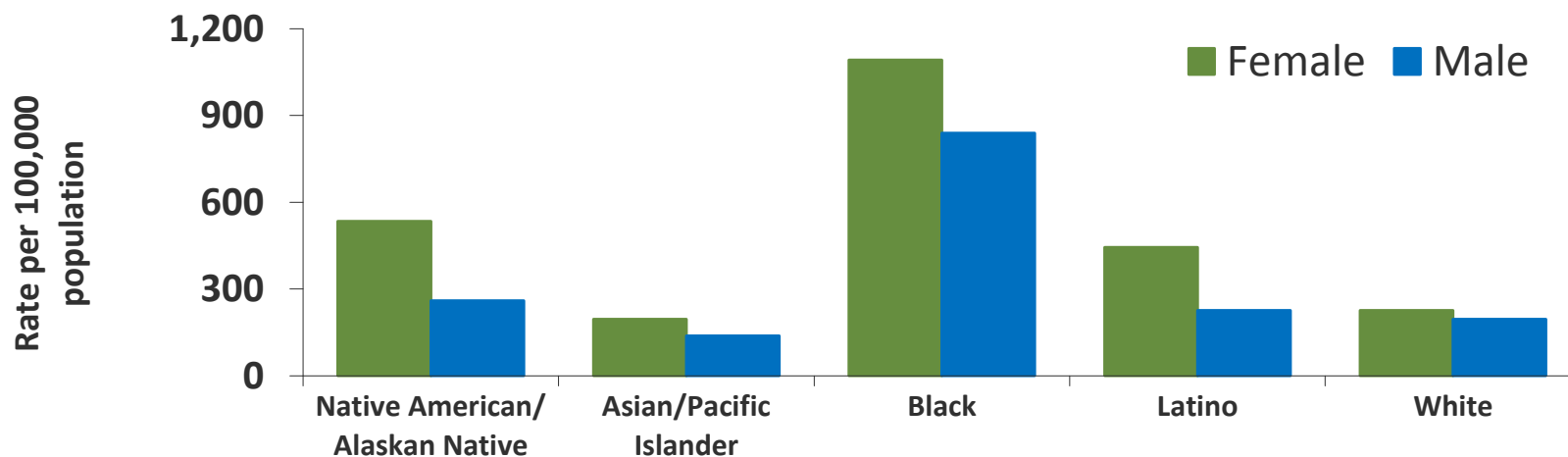
Adolescents and young adults are the populations most impacted by chlamydia



Note: Since this disease is often asymptomatic, reported cases may reflect chlamydial infections identified through screening programs offered primarily to women.

Significant disparities in chlamydia rates exists across racial-ethnic groups

Chlamydia, Incidence Rates by Gender and Race/Ethnicity, CA 2017



Rev. 7/2018

Note: Race/Ethnicity was "Not Specified" for 35.7% of female cases and 31.5% of male cases for the given year. Since this disease is often asymptomatic, reported cases may reflect chlamydial infections identified through screening programs offered primarily to women.

Why is chlamydia screening important?

Most common reportable
communicable disease

Curable bacterial
sexually transmitted
infection

Highest reported rates
among adolescent +
young adult females
(15-24 years)

Infection usually
asymptomatic + can lead
to serious health outcomes

Chlamydia is most often asymptomatic



Females

70-95% asymptomatic

If symptoms:

- Vaginal discharge
- Heavy or prolonged menses
- Spotting
- Dysmenorrhea (painful periods)
- Dyspareunia (painful sex)



Males

40-90% asymptomatic

If symptoms:

- Penile discharge
- Dysuria

Chlamydia Screening Recommendations

American Academy of Pediatrics (AAP) – Bright Futures	<ul style="list-style-type: none">all sexually active youth <u>annually</u>
American Academy of Family Physicians (AAFP)	<ul style="list-style-type: none">sexually active females ≤ 24 yrs. <u>annually</u> & others at increased risk
American Congress of Obstetricians & Gynecologists (ACOG)	<ul style="list-style-type: none">sexually active females ≤ 24 yrs. <u>annually</u> & others at increased risk
Centers for Disease Control & Prevention (CDC)	<ul style="list-style-type: none">sexually active females ≤ 24 yrs. <u>annually</u>adolescent males in high prevalence areas
US Preventive Services Task Force (USPSTF)	<ul style="list-style-type: none">sexually active females ≤ 24 yrs. <u>annually</u> & others at increased risk

AAP Performing Preventive Services: A Bright Futures Handbook (pg. 147) – [link here](#)

CDC 2015 STD Screening Guidelines – [link here](#)

USPSTF Recommendations for STI Screening – [link here](#)

Who gets screened for chlamydia?



Females

- <25 yrs. annually* if ever sexually active
- ≥25 yrs. if at risk
- All pregnant <25 yrs.
- Pregnant ≥25 yrs. if at risk

Men who have sex with women

- High-prevalence settings



Men who have sex with men (MSM)

- At least annually*
- Exposed sites: genital, rectal, pharyngeal

After treatment

- All patients should be re-screened ~3 months after being treated for a chlamydia infection



The U.S. Preventive Services Task Force (USPSTF) specifies risk factors for chlamydia and gonorrhea

Gender/Age

- Females ages 15-24 years
- Males ages 20-24 years

Racial Disparities

- Black and Hispanic populations have higher rates vs. Whites

Sex Partners

- New sex partner
- >1 sex partners
- Sex partner w/ STD
- Sex partner w/ other partners

Behavior

- Inconsistent condom use
- Substance abuse
- Exchanging sex for money or drugs

Special Populations

- Incarcerated populations
- Military recruits
- Public STD clinic patients

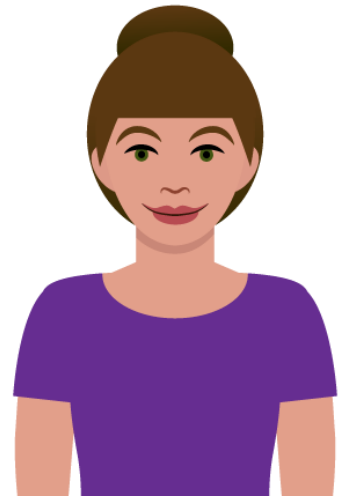
STD History

- Past STDs
- Concurrent STDs

Meet Jade. Jade has PID.


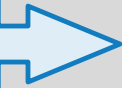

Jade is a 16-year-old female and a student at the local high school. She comes to your clinic as a walk-in patient with a complaint of severe lower abdominal pain. Upon exam, the clinician notes uterine tenderness and diagnoses pelvic inflammatory disease (PID). She sends in a chlamydia test for Jade, which later comes back positive.

Two months earlier, Jade had come to your clinic with her mom for her annual well-check visit. She had no symptoms and was not screened for chlamydia.



Were there opportunities missed that could have prevented Jade's PID?

Clinical Syndromes Caused by Chlamydia

	Local Infection	Complication	Sequelae
Females 	Cervicitis Urethritis Proctitis Conjunctivitis	Pelvic Inflammatory Disease (i.e., Salpingitis, Perihepatitis) Endometritis Reactive arthritis (rare)	Infertility Ectopic pregnancy Chronic pelvic pain HIV risk Chronic arthritis (rare)
Males 	Urethritis Proctitis Conjunctivitis	Epididymitis Reactive arthritis (rare)	HIV risk Chronic arthritis (rare)
Infants 	Conjunctivitis Pneumonitis Pharyngitis Rhinitis	Eye and lung infections	Rare, if any

Jade's well-check visit (two months earlier...)

Jade comes to your clinic with her mom for her annual well-check visit.

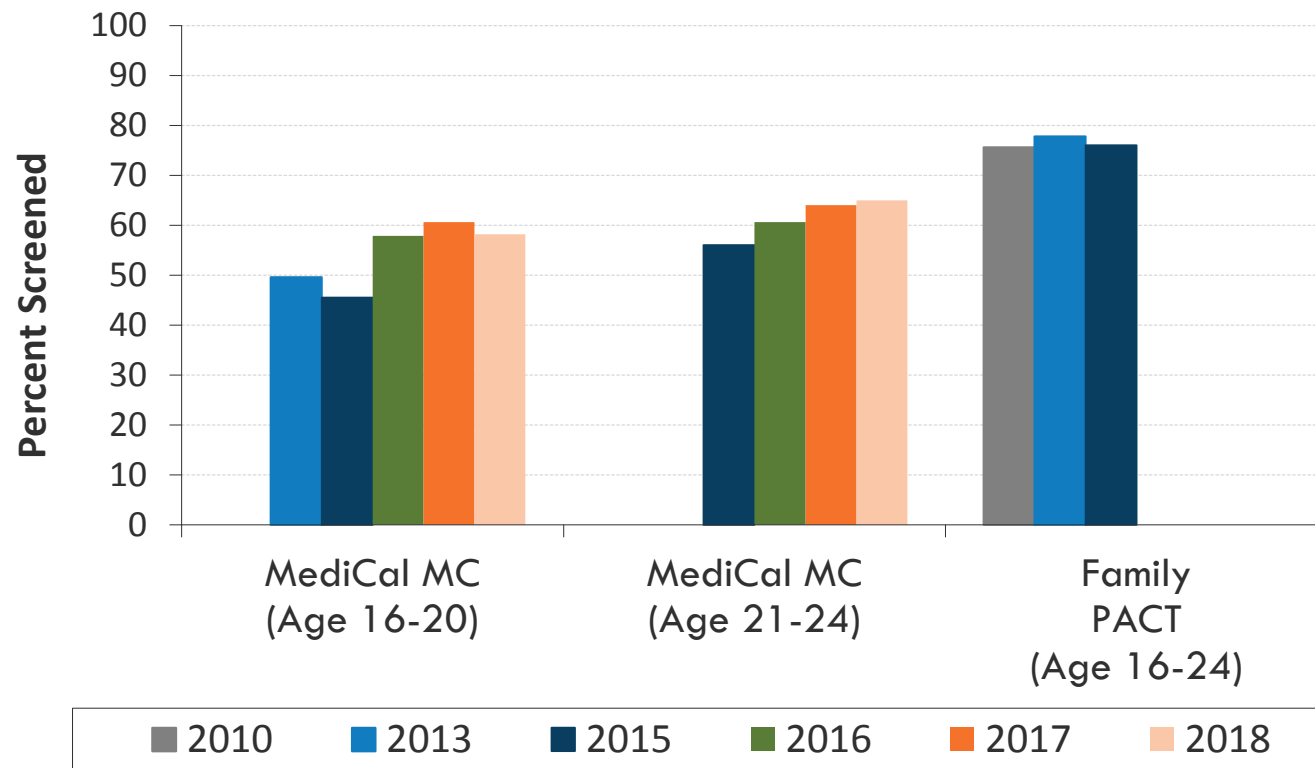
Your reception staff greets Jade's mom, gives her all of the forms for Jade's visit, including Jade's health history questionnaire, and asks her to have a seat with Jade in the waiting room.



Is there anything your receptionist could have done differently to support a more adolescent-friendly experience for Jade?

Chlamydia screening rates in California need improvement

Estimated Chlamydia Screening Coverage (HEDIS), Females Age 15–24, CA, 2010-2018



Source: [Medicaid.gov, Quality of Care Performance Measurement, Adult & Child Health Care Quality Measures](https://www.medicaid.gov/Quality-Of-Care-Performance-Measurement/Adult-Child-Health-Care-Quality-Measures) (data not available for 2010 for either age group, nor for 2013 in the 21-24 year age group); California DHCS Division of Medi-Cal Managed Care, DHCS Office of Family Planning (data after 2015 not available)

Jade's sexual activity assessment

Jade's mom completes Jade's health history questionnaire, the Staying Healthy Assessment (SHA). She answers "No" to the question asking whether Jade has ever had sex, and skips the other sexual-health related questions. She returns this questionnaire with the other forms to reception.



Should Jade's mom be filling out her health history form?
How could clinic protocols be adjusted to make this less likely?

**Recommendations for the Laboratory-Based
Detection of *Chlamydia trachomatis* and
Neisseria gonorrhoeae — 2014**

**Nucleic acid amplification tests (NAATs) are recommended
for detection of genital tract infections in men and women**

- highly sensitive and specific compared to culture
- less dependent on specimen collection and handling

Optimal specimen types are:

- First catch urine for men
- Self collected vaginal swabs from women

**NAATs are recommended for: detection of rectal and
oropharyngeal infections**

- Recently FDA-approved for rectal and pharyngeal specimens

Jade is roomed

Jade and her mom are called back for vitals and rooming. The Medical Assistant takes Jade's height, weight, and blood pressure in a vitals station while mom looks on, and then puts Jade and her mom in an exam room to wait for the clinician.

Think about different ways that Jade and her mom could have been roomed to provide opportunities for private screening and specimen collection...



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Think about different ways that Jade and her mom could have been roomed to provide opportunities for private screening and specimen collection...



At what age can minors in CA consent to confidential sexual health care?

CA Minor Consent & Confidentiality Laws Related to Sexual Health Services

- CA Minors may seek and consent to any of the following services:
 - **Contraception (no age minimum)**
CA Family Code § 6925
 - **Pregnancy-related services (no age minimum)**
CA Family Code § 6925
 - **STD & HIV prevention, testing, treatment (12 years and older)**
CA Family Code § 6926; CA Health & Safety Code § 121020
 - **HPV & Hepatitis B vaccines (12 years and older)**
CA Family Code § 6926
- The healthcare **provider is not permitted to inform a parent or legal guardian** about minor consent sexual healthcare services without the minor's written authorization.

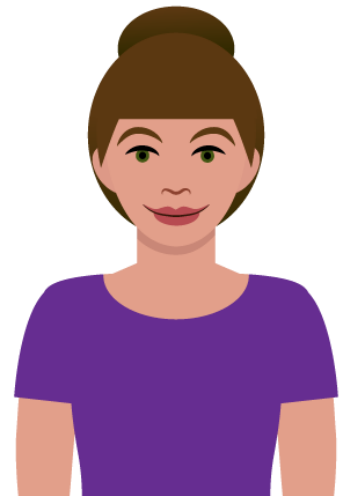
CA Health & Safety Code § § 123110(a); 123115(a)(1); CA Civic Code § 56.10, 56.11

Jade gets alone time with her clinician

The clinician enters the room, reviews the SHA questionnaire, and begins her exam. After, the clinician tells Jade's mom that she'll need a few minutes alone with Jade, given her age.

Jade's mom is surprised but agrees to step out into the hallway where she stands and waits outside the door.

The clinician reads through a list of questions from the computer about a number of sensitive topics, including asking Jade whether she has had sex. Jade says no.

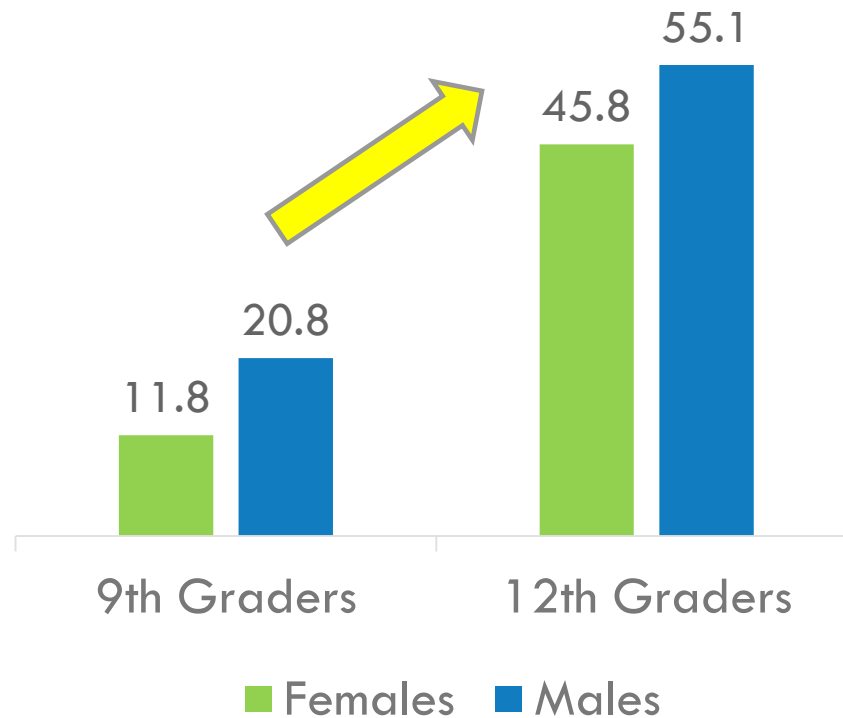


What did the clinician do well?

What are some opportunities for improvement?

What percentage of CA high-school youth report ***Ever having had sexual intercourse?***

What percentage of CA high-school youth report *Ever having had sexual intercourse*?



Overall, 32.3% of CA high-school students report ever having sex

Source: CA Youth Risk Behavior Survey, 9-12th grades, 2017

Best Practice Implementation Strategies for Improving Chlamydia Screening



To improve chlamydia screening in primary care settings,
focus on protocol changes across these 4 categories



Creating
a Welcoming
Environment



Ensuring
Minor Consent &
Confidentiality



Assessing
Sexual Activity as
Part of Routine
Care



Routinizing
Chlamydia
Screening

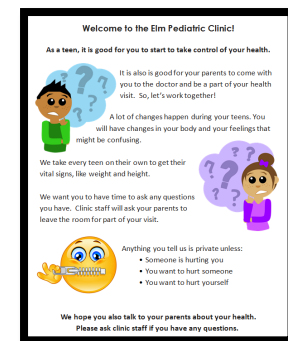
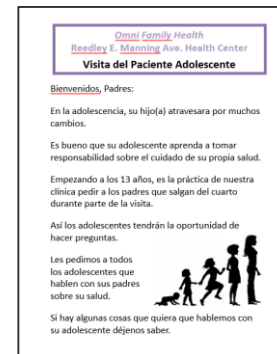
Category 1: Creating a welcoming environment



Create a **confidential space** to complete risk assessment forms



Proactively inform parents + patients about minor consent & provider alone time protocols



Category 2: Ensuring minor consent + confidentiality



Ensure all adolescents have **alone time** with their provider (and parents aren't waiting outside of door).



Ensure **staff training** on CA minor consent and confidentiality laws and **document** sensitive information **in confidential locations** in the EHR.



Category 3: Assessing sexual activity as part of routine care



Conduct an annual sexual activity assessment using a **standard format** and document in a **confidential, standard location** in EHR

Don't Forget Your HEADSSS	
Social History Narrative Tips	HEADSSS Assessment
<ul style="list-style-type: none">Document as a Sensitive Note –Open a new note & click the “sensitive” button on top rightDate your HEADSS entryDo not put HEADSS or other confidential info in provider notes or social historyIf you cannot complete a HEADSS during the visit, write in “HEADSS deferred” with the date	<p>Write .ccheadsss in the note for the template</p> <p>Full HEADSSS may include:</p> <ul style="list-style-type: none">H: HomeE: Education/EmploymentA: ActivitiesD: Drugs (incl. alcohol and tobacco)S: SexualityS: SafetyS: Suicidality/Depression <p>Other “S” topics may include Spirituality or Strengths.</p>

Adolescent Sexual History Algorithm

Setting the stage

- “I talk to all of my patients about puberty and sex because they are important parts of health. Everything we talk about is between us, unless you tell me you might hurt yourself, might hurt someone else, or that someone has been hurting you.”
- (Relationships) “Some of my teen patients are exploring new relationships. Do you have a crush on anyone? Are you dating or seeing anyone?”
- Consider including this discussion during conversations about menstruation or puberty

What questions do you have about your body and/or sex?

Have you ever had sex with someone?
By “sex” I mean vaginal, which is penis in vagina, oral, which is penis or vagina in someone’s mouth, or anal, which is penis in butt.

If No:

- (1) Do you have someone you can talk to when you feel ready to have sex?
- (2) You can come back and talk to me about sex at any time.
- (3) At least once a year we test young people who are having sex for STDs because they are really common and don’t usually have any symptoms. California law says we can do this without telling your parents, if you need us to.

If Yes:

- (1) Test for chlamydia/gonorrhea.
- (2) Proceed to questions on back page.

Intro language: “I’m going to ask you several questions about your experiences with sex, so that I can help you in making/keeping these experiences positive and healthy.”

Category 4: Routinizing Chlamydia screening



Collect **universal urine**
(with some exceptions by visit type)



Collect **private contact info** (i.e.,
cell phone) for all patients tested

Patient's direct cell:
510-555-1234



Opt-out chlamydia screening – The wave of the future?

Risk-Based

- ✓ Sexual history taken
- ✓ Test ordered by provider
- ✓ Can be augmented by universal urine collection and/or standing orders, but still dependent on provider to “check the box”

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Opt-Out

- ✓ Regardless of whether sexual history is taken
- ✓ Standing orders to screen age eligible females (15-24)
- ✓ Universal urine/vaginal swab collection
- ✓ All females are eligible for screening unless:
 - Negative CT test in past 12 months
 - Patient refuses testing

Fresno CRMC Success Story



Fresno Community Regional Medical Center's (CRMC) Ambulatory Care Center's Pediatric Clinic – QI project:

1. *One 4-day quality improvement (QI) onsite event ("Kaizen") held focused on well-check visits only. Included:*
 - *Clinical best practice training*
 - *QI facilitation support*

Fresno CRMC Success Story



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1. *One 4-day quality improvement (QI) onsite event ("Kaizen") held focused on well-check visits only. Included:*
 - *Clinical best practice training*
 - *QI facilitation support*
2. *Six months later, one 2-day QI Kaizen event held focused on drop-in and follow-up visits*

Fresno CRMC Success Story



Fresno Community Regional Medical Center's (CRMC) Ambulatory Care Center's Pediatric Clinic – New Protocols Tested and Adopted:

1. *Parents informed of adolescent visit policy in letter sent home and given at check-in*
2. *Separated adolescent forms at check-in and had youth sit in private chair to complete forms, return directly to reception*

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6. *Clinician performed comprehensive **verbal** assessment (i.e., Bright Futures: HEEADSSS)*

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5. *Clinician escorted parent to the waiting room to initiate alone time with patient*
6. *Clinician performed comprehensive **verbal** assessment (i.e., Bright Futures: HEEADSSS)*
7. *Trained all staff on CA Minor Consent and Confidentiality laws and determined confidential, standard location for noting sensitive info in EHR*

Fresno CRMC Success Story

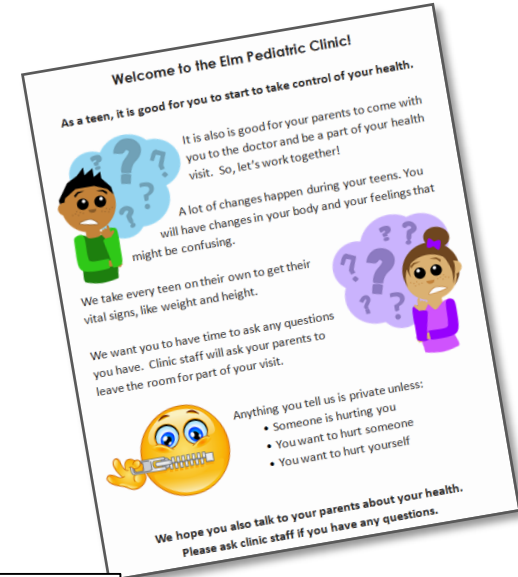
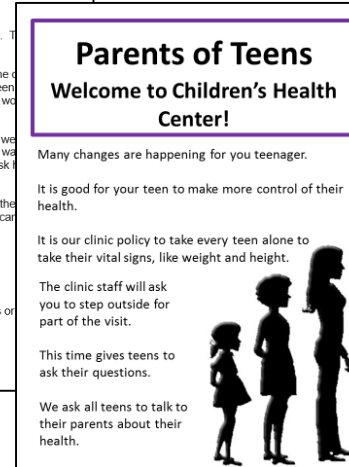
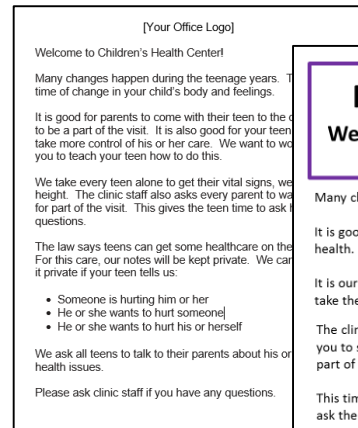


Fresno Community Regional Medical Center's (CRMC) Ambulatory Care Center's Pediatric Clinic – Clinical Resources Developed:

Patient Letter



Patient Poster for Intake Room



Parent Letter and Flyer



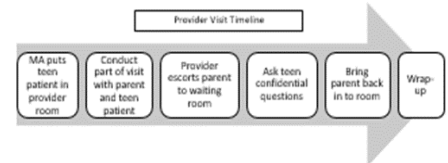
Fresno CRMC Success Story



Fresno Community Regional Medical Center's (CRMC) Ambulatory Care Center's Pediatric Clinic – Scripts, Written, Protocols, Training Guides developed to sustain the change:

Tips and Best Practices:	
Let parents and adolescent know about the health center policy	"Let me tell you how things work in our office for adolescent patients, we are all going to first meet together to review medical history etc. and then I will ask the parent to step out of the room so I can talk to the patient alone."
Acknowledge parents' concerns	Use sympathetic language such as "I understand" or "I hear what you are saying" "I know it is a bit of a change when you child goes through adolescents"
Providing parents with an opportunity to provide input	"When your child was young he/she needed you to advocate on their behalf and now during this new stage of development, it is appropriate for her/him to begin to take more responsibility for their own health." "Our hope is that parents and children will be able to openly discuss everything, but if there is something your child does not feel comfortable sharing with you, we want them to have another responsible adult who they trust, like a health care provider, who provides accurate and factual information." "Is there anything you'd like me to discuss with your child when we speak alone?"

Escorting Parents of Adolescents to the Waiting Room	
What is it?	<ul style="list-style-type: none"> Escorting adolescent parents to the waiting room So adolescent patients can have time alone with the provider without worrying about their parents listening in from the hall
Why is it important for the clinic?	<ul style="list-style-type: none"> To make the parents feel more comfortable while their adolescents are alone in the exam room with the provider Gives the provider an opportunity to speak to the parent alone
Who does it?	<ul style="list-style-type: none"> The provider escorts the parent
When do you do it?	<ul style="list-style-type: none"> After rooming intake and taking the adolescent's vitals, before the exam starts
Where do you do it?	<ul style="list-style-type: none"> Starting in the exam room and walking the parent to the waiting room
What are the steps?	<ul style="list-style-type: none"> Start with telling the parent that you will now see the adolescent alone in the room to talk about any health concerns they have Then ask the adolescent to stay in the room Escort the parent to the waiting room After finishing the confidential time with the adolescent, return to the waiting room and ask the parents to come back in to the room for final wrap up and notes
Other details:	<ul style="list-style-type: none">
Exceptions to the rule:	<ul style="list-style-type: none"> There are no exceptions - all adolescents need private time with the provider starting at age 12.



Sexual Activity Documentation	
What is it?	<ul style="list-style-type: none"> Consistent documentation of sexual activity status in a standardized, confidential location within the EHR.
Why is it important for the clinic?	<ul style="list-style-type: none"> Will inform and support the provision of best practice sexual health care for adolescents who need these services; Will ensure that a patient's sexual health information is confidentially protected from parent/guardian access, as per state law.
Who does it?	<ul style="list-style-type: none"> Clinic Providers
When do you do it?	<ul style="list-style-type: none"> During private time with adolescent patients in provider room.
Where do you do it?	<ul style="list-style-type: none"> Documentation within the Social History Screen using the Sexually Active Check Box
What are the steps?	<ul style="list-style-type: none"> Check "YES" if the adolescent has EVER been sexually active (sex of any type: vaginal, oral, anal) Check "NO" if the adolescent has NEVER been sexually active (no sex of any type) Do NOT use "NOT CURRENTLY" check box
Other details:	<ul style="list-style-type: none"> Can use this section to document other sexual risk assessment information (i.e., gender of sex partners has specific check boxes, free text comments for birth control info)
Exceptions to the rule:	<ul style="list-style-type: none"> There are no exceptions - performed for all teens age 12 and older at all visits regardless of reason for visit

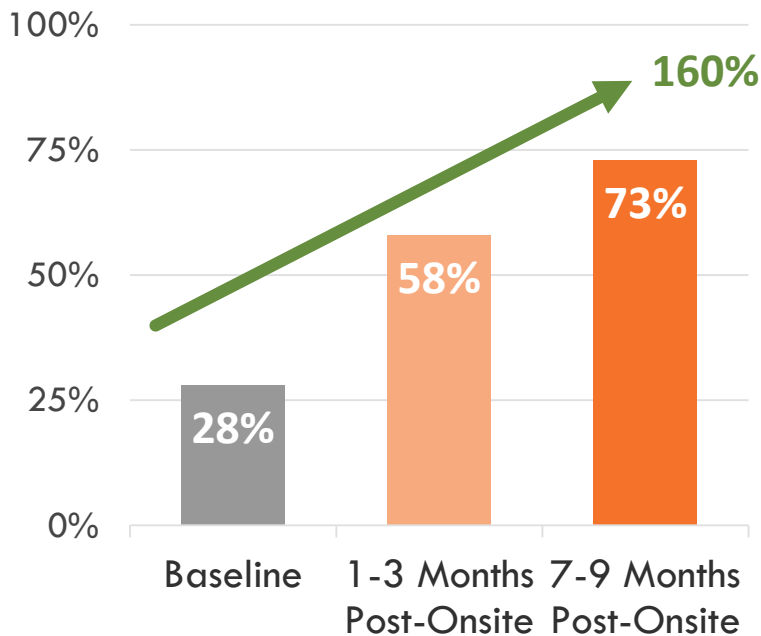
Fresno CRMC Success Story: Practice Improvement Results

Annual Chlamydia Screening Rate Adolescents Ages 12-19 years

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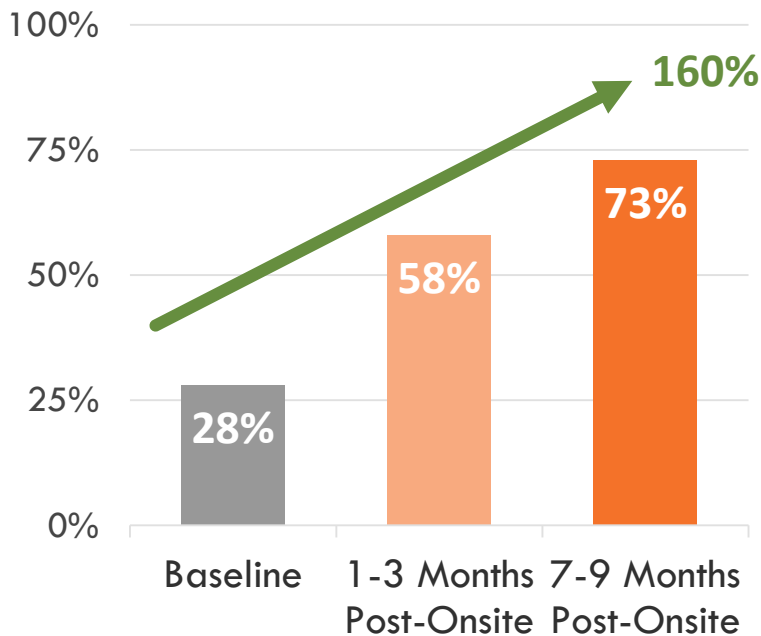
Well-Check Visits



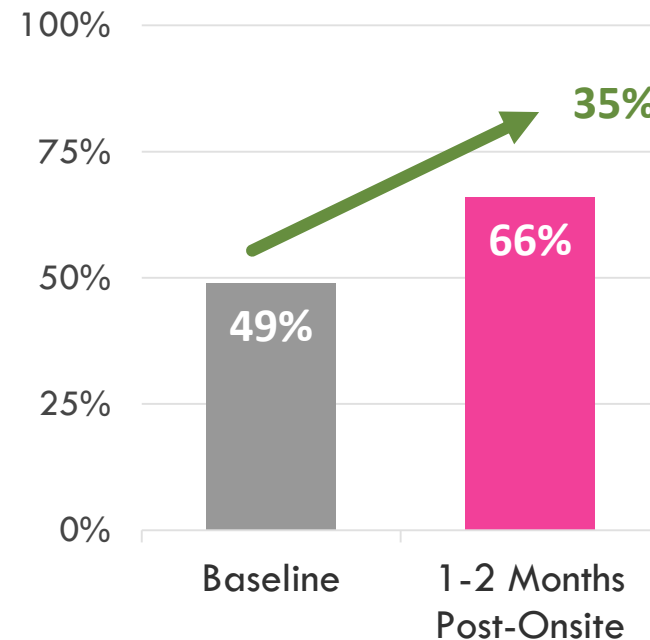
Fresno CRMC Success Story: Practice Improvement Results

Annual Chlamydia Screening Rate Adolescents Ages 12-19 years

Well-Check Visits



Drop-In & Follow-Up Visits

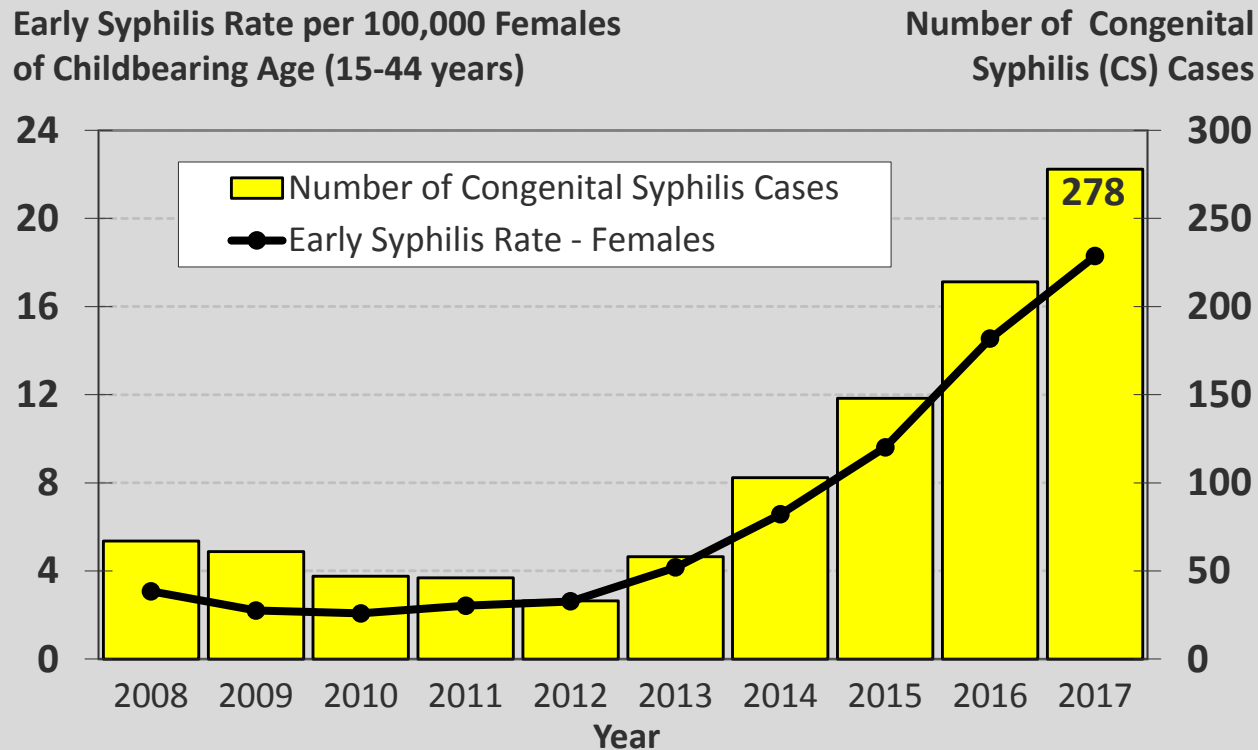


Important Clinical Management Best Practices for Patients who Test Positive for Chlamydia



California is experiencing a syphilis epidemic

Congenital Syphilis Cases versus Female Early Syphilis*
Incidence Rates, California, 2008–2017



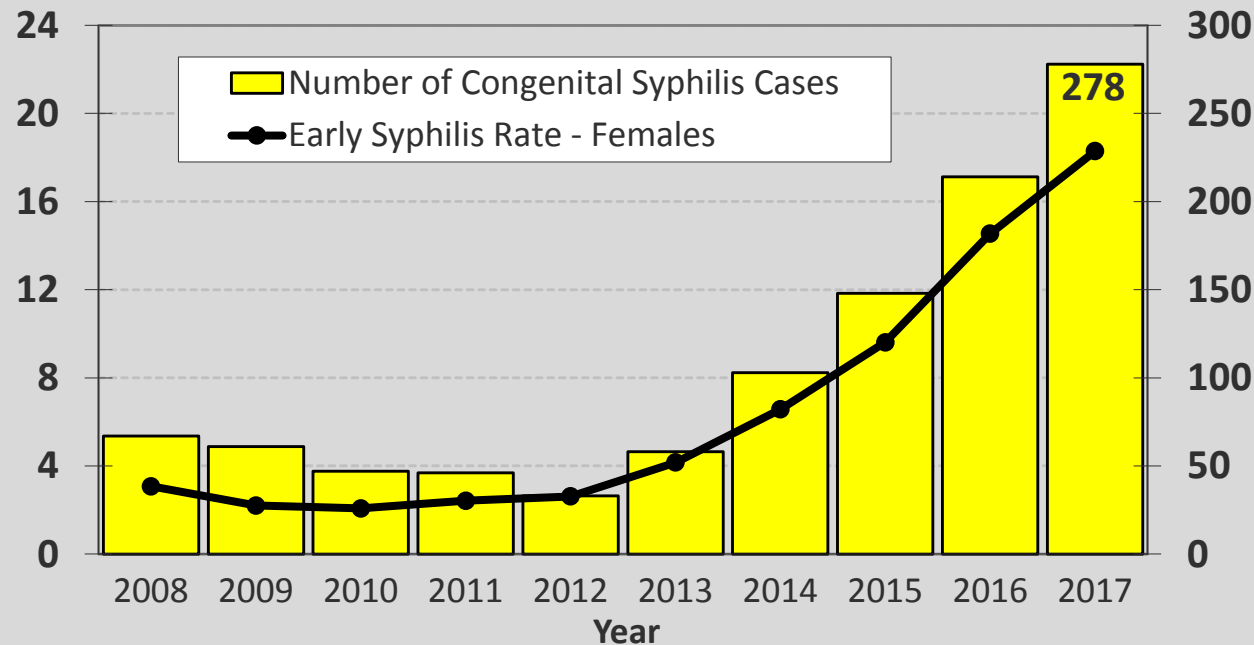
* Includes primary, secondary, and early latent syphilis.

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Congenital Syphilis Cases versus Female Early Syphilis*
Incidence Rates, California, 2008–2017

Early Syphilis Rate per 100,000 Females
of Childbearing Age (15-44 years)

Number of Congenital
Syphilis (CS) Cases



* Includes primary, secondary, and early latent syphilis.

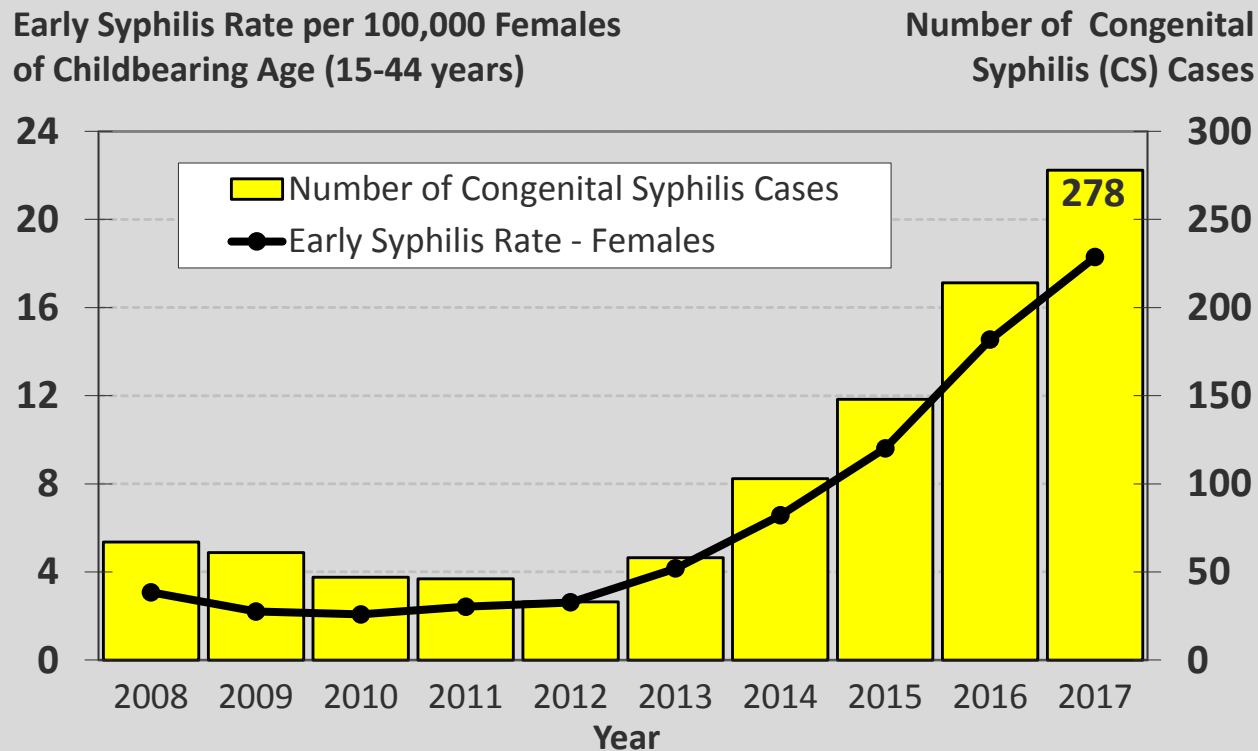
2018
Preliminary CS
Cases = 329

900% increase
from 2012



California is experiencing a syphilis epidemic

Congenital Syphilis Cases versus Female Early Syphilis*
Incidence Rates, California, 2008–2017



2018
Preliminary CS
Cases = 329

900% increase
from 2012

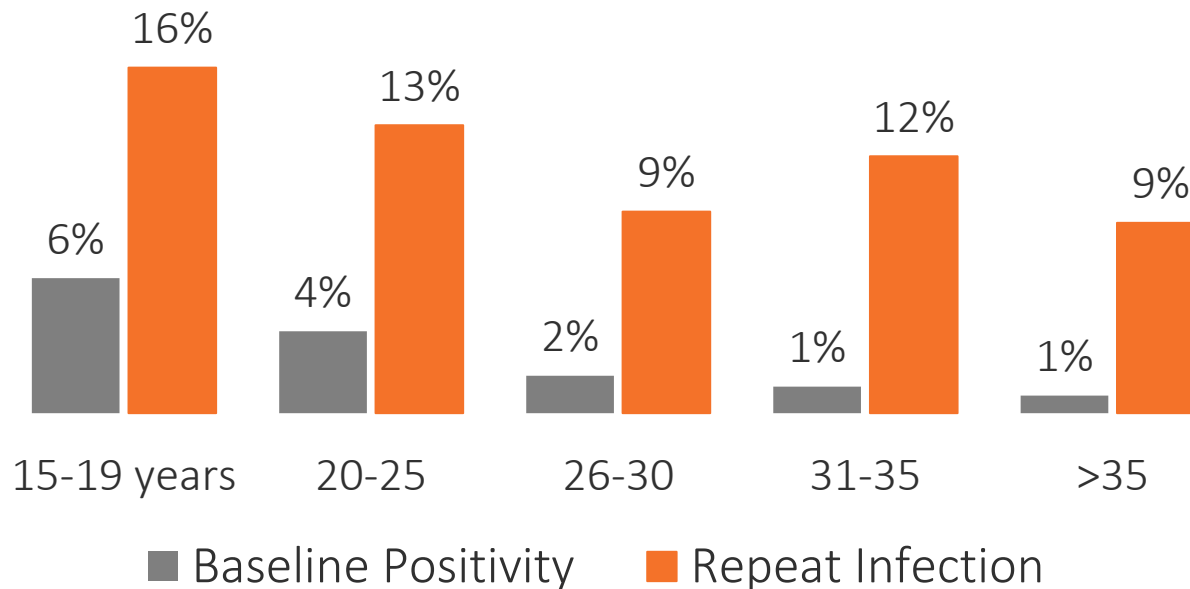


* Includes primary, secondary, and early latent syphilis.

- If a patient tests **positive for chlamydia** (or gonorrhea), be sure to **screen for syphilis** (and HIV) = *The “Core 4” STDs*

Also, chlamydia reinfection is common

Regardless of age, reinfection rates at retest are often 2-3 times higher than baseline positivity rates.



And chlamydia reinfection is dangerous

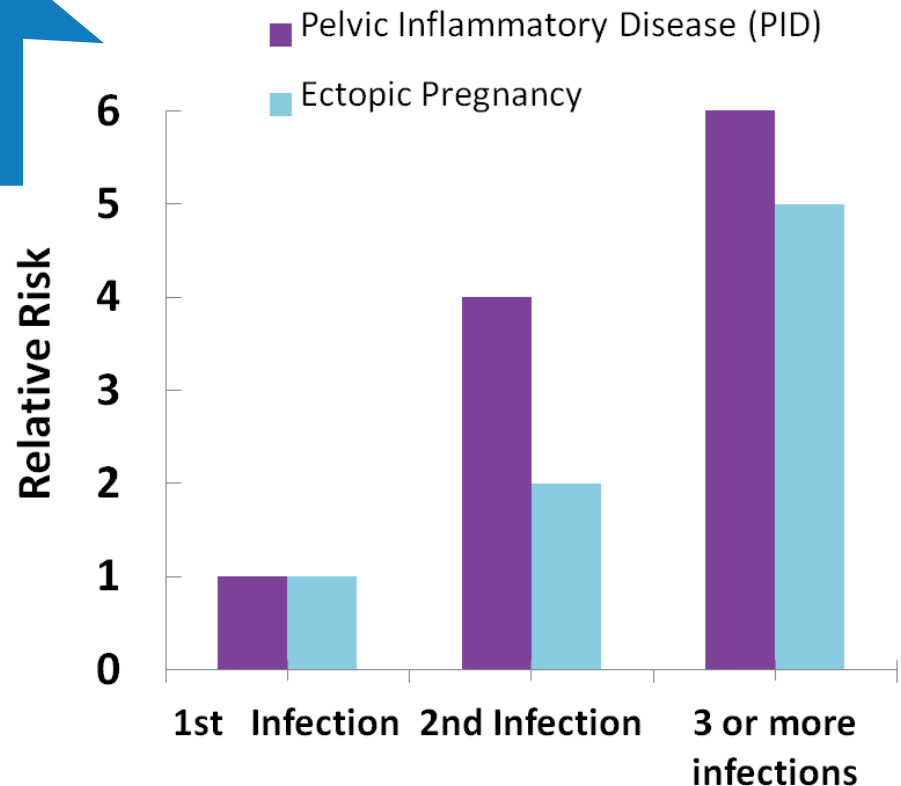
Highly associated with increased risk for adverse reproductive health consequences.

2nd infection:

- 4x risk of PID
- 2x risk of ectopic pregnancy

3+ infections:

- 6x risk of PID
- 5x risk of ectopic pregnancy



Chlamydia reinfection is common and dangerous

To reduce the likelihood and consequences of repeat infection, for patients who are treated for a positive chlamydia (or gonorrhea) infection, it is critical to also:

- (1) **treat their sex partners**, and
- (2) **rescreen index patient** ~3 months after treatment



Best Practices and Early Detection of Repeat Chlamydial and Gonococcal Infections: Effective Partner Treatment and Patient Retesting Strategies for Implementation in California Health Care Settings

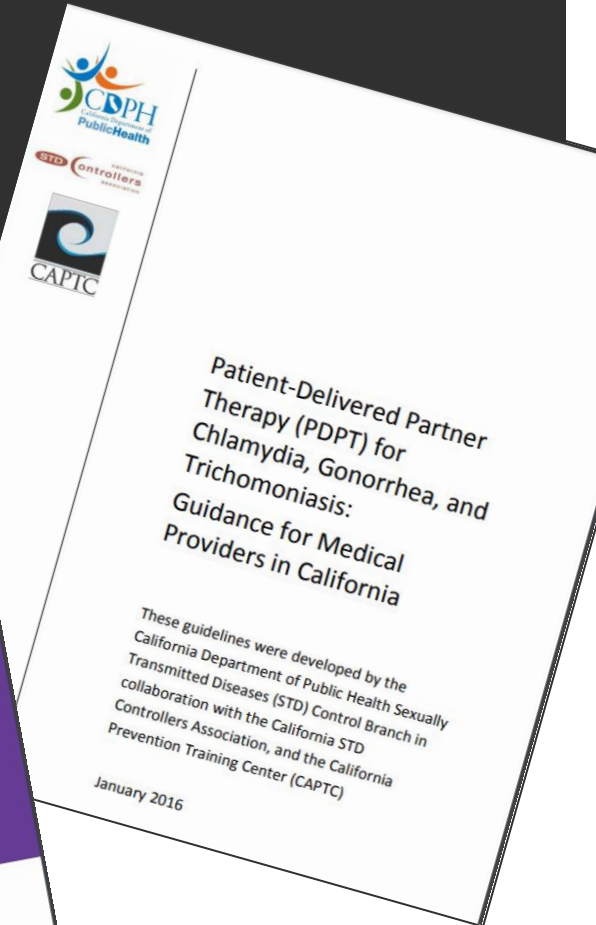
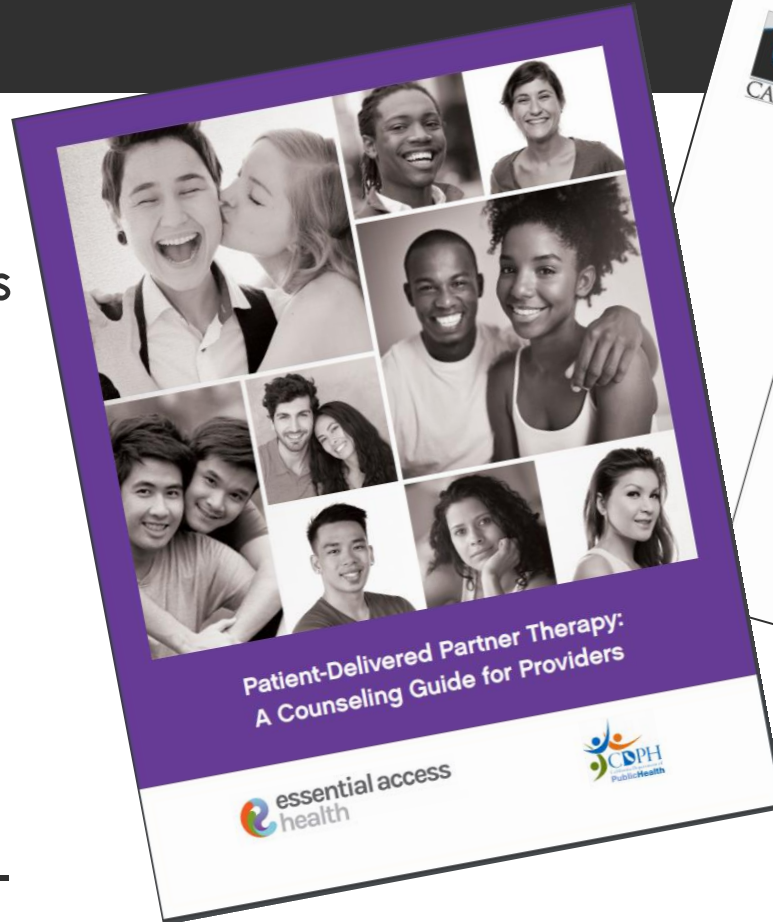
These guidelines were developed by the California Department of Public Health (CDPH) Sexually Transmitted Disease (STD) Control Branch in collaboration with the: California Family Health Council, California STD/HIV Prevention Training Center, Los Angeles County Department of Public Health, San Francisco Department of Public Health and the California Department of Health Care Services Office of Family Planning

Revised February 2016

https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/Best_Practices_for_Preventing_RepeatCT_Inf.pdf

Effective Partner Treatment Options

- (1) Ask patients to bring their partners in with them for a co-treatment visit, or
- (2) Offer **patient-delivered partner therapy (PDPT)** via prescription or pre-filled partner pack



https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/Essential_Access_PDPT_Counseling_Guide.pdf

<https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/Clinical-Guidelines-CA-STD-PDPT.pdf>

Free CA Patient Delivered Partner Therapy Distribution Program

- This program provides **free chlamydia + gonorrhea medication** to eligible clinic sites
- Participating clinic sites dispense **pre-packaged medication** to patients diagnosed with either infection to give the medication to their sex partner(s) for treatment
- Publically-funded clinical practices are eligible for this program



www.essentialaccess.org/pdpt

Chlamydia screening + management of positive test results, in summary: *Screen, Screen, Treat-Treat, Screen*



Screen for chlamydia + gonorrhea
(dual test)

If screen is positive for either infection:



Screen for syphilis + HIV

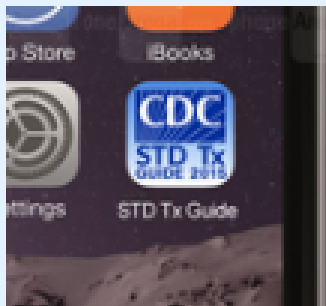


Treat patient + **Treat** partners

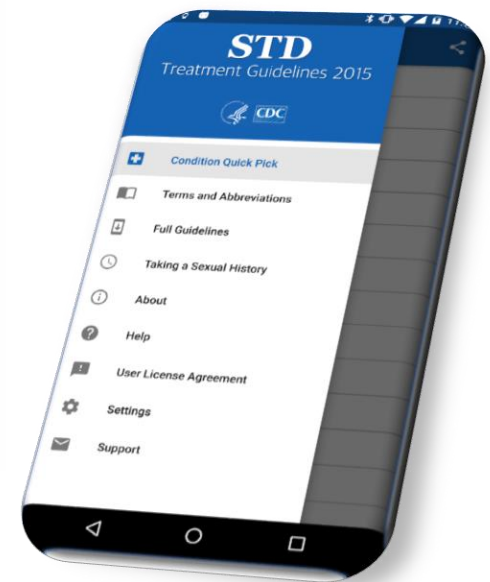


Re**Screen** in 3 months

Hey! There's an app for that...



Download the 2015 STD Treatment (Tx) Guide app, an easy-to-use reference that combines information from the STD Treatment Guidelines as well as MMWR updates, and features a streamlined interface so providers can access treatment and diagnostic information. The free app is available for [Apple devices](#) and [Android devices](#).



STD Clinical Consultation Network (STDCCN)

- Provides STD clinical consultation services to healthcare providers nationwide (within 1 to 5 days, depending on urgency)
- Your consultation request is linked to a CDC-funded expert faculty from your closest STD Clinical Prevention Training Center (i.e., the CA PTC)

www.STDCCN.org



National Network of
STD Clinical Prevention
Training Centers

STD Clinical Consultation Network

Important for Requestors to Consider

The Clinical Consultation Service is intended for licensed healthcare professionals and STD program staff. We do not provide direct medical care, treatment planning, or medical treatment services to individuals.

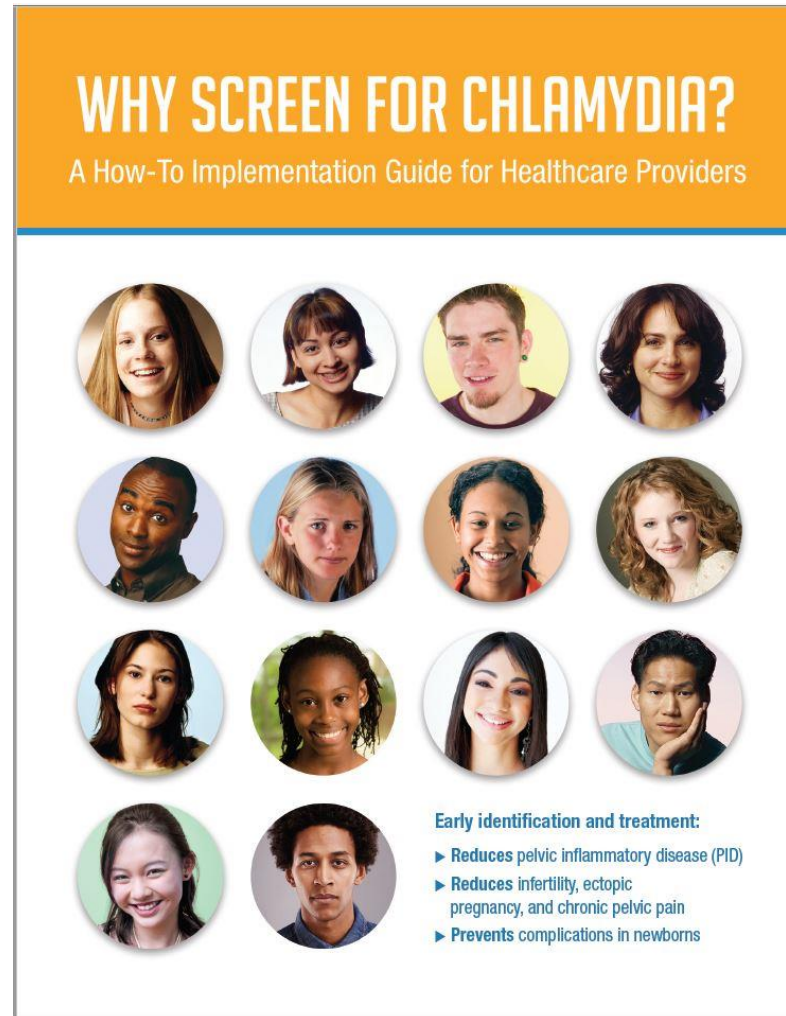
The information provided through the Clinical Consultation Service is not a replacement for local expertise or your state STD program protocols. Information is offered as clinical decision support, is advisory in nature and is not intended to replace local healthcare decision-making or provision. Requestors are free to disregard any advice offered. Final clinical decisions are the sole responsibility of the healthcare provider.

Additional Resources



Why Screen for Chlamydia?

A How-To Implementation Guide for Healthcare Providers



url: http://chlamydiacoalition.org/pdfs/Why_Screen.pdf

STD Clinical QI Resource Library

National STD Quality Improvement Center



Image	Title	Summary	Topics	Resource Types	Download File
	Adolescent Alone Time Policy Letter	Hand this out to adolescents to let them know what to expect during their well check.	Adolescent-friendly environment, Minor consent and confidentiality	Letter	Word
	Chlamydia Screening Protocol	Use this protocol to train staff on the chlamydia screen ordering process.	Chlamydia screening	Clinic protocol	Word
	Confidentiality Poster	Hang this in exam rooms to let adolescents know about their confidentiality rights.	Minor consent and confidentiality	Poster	PowerPoint
	Medical Assistant Script for Sensitive Conversation Starters during Alone Time	Use this script to train clinic staff that have alone time with an adolescent on how to start conversations about sensitive topics.	Assessing sexual activity, Chlamydia screening	Clinic script	Word

- Implementation resources
 - tools, scripts, sample protocols, posters, patient education materials
- Downloadable, editable

<https://californiaptc.com/national-quality-improvement-center/>

Minor Consent & Confidentiality for Sexual Health Services in California:

A Training for Clinical Settings

NEW:
**On-Demand
Course for
Clinical
Staff
Training**



This FREE training will provide participants with:

- An overview of California laws that guarantee a minors right to access confidential sexual health services
- An overview of the role clinical practices and healthcare systems have in ensuring these protections
- Resources to support the implementation of these laws in a clinical setting

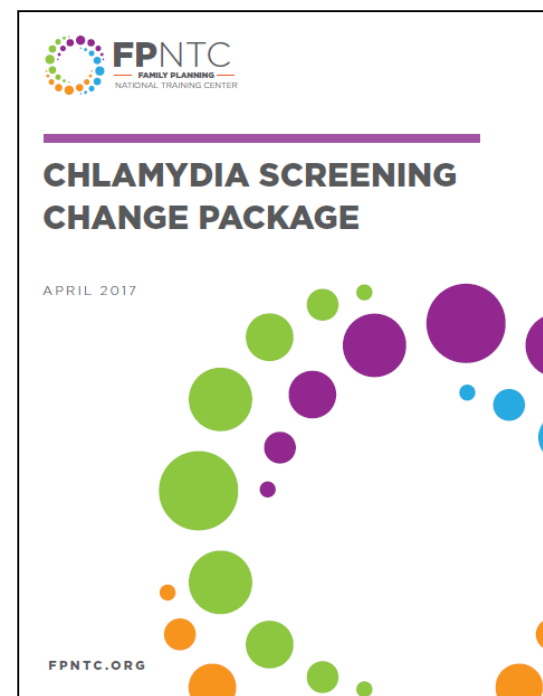
To access, visit: <http://bit.ly/ClinicianMinorConsentTraining>



Chlamydia Screening Change Package

Family Planning National Training Center

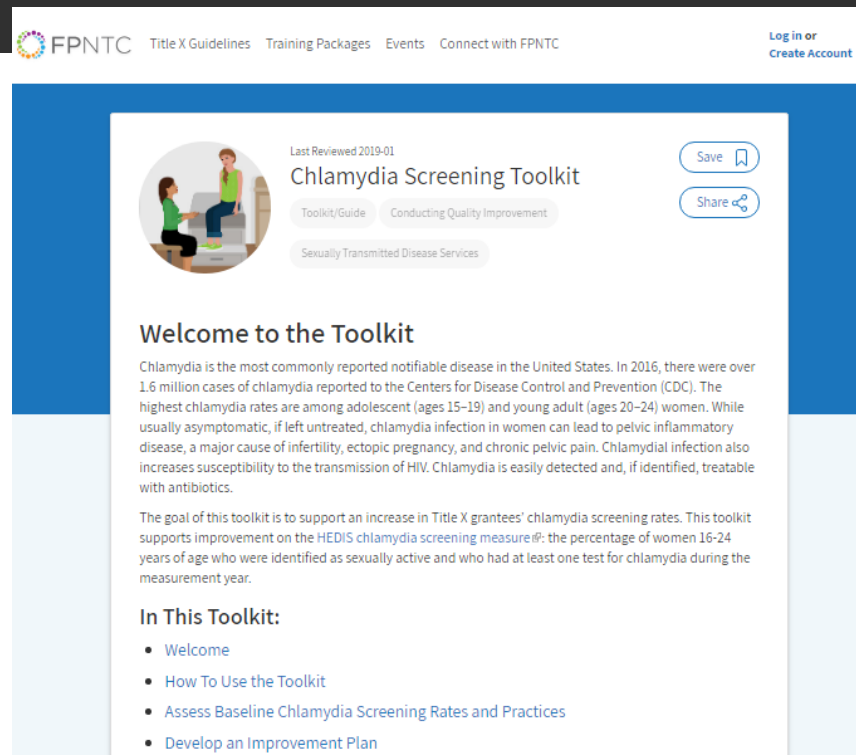
1. Include chlamydia screening as a part of **routine** clinical preventive care
2. Use **normalizing and opt-out language** such as, *“I recommend a test for chlamydia to all my clients under 25.”*
3. Use the least invasive, high-quality, recommended **laboratory technologies** available
4. Utilize diverse payment options to **reduce cost as a barrier**



Chlamydia Screening Toolkit

Family Planning National Training Center

- Best Practice Recommendations
- Action Steps
- Training Guides
- Other Implementation Resources



The screenshot shows the homepage of the Chlamydia Screening Toolkit. At the top, there is a navigation bar with the FPNTC logo, links to 'Title X Guidelines', 'Training Packages', 'Events', and 'Connect with FPNTC', and a 'Log in or Create Account' button. The main content area features a circular illustration of two people talking. To the right of the illustration, it says 'Last Reviewed 2019-01' and 'Chlamydia Screening Toolkit'. Below this, there are three tabs: 'Toolkit/Guide' (selected), 'Conducting Quality Improvement', and 'Sexually Transmitted Disease Services'. There are also 'Save' and 'Share' buttons. The main text welcomes users to the toolkit and provides background information on chlamydia. It states that chlamydia is the most commonly reported notifiable disease in the United States, with over 1.6 million cases reported to the CDC in 2016. It notes that the highest rates are among adolescents and young adults, and that untreated infection can lead to serious complications. The goal of the toolkit is to support an increase in Title X grantees' chlamydia screening rates. A list of 'In This Toolkit' items includes: Welcome, How To Use the Toolkit, Assess Baseline Chlamydia Screening Rates and Practices, and Develop an Improvement Plan.

FPNTC Title X Guidelines Training Packages Events Connect with FPNTC Log in or Create Account

Last Reviewed 2019-01
Chlamydia Screening Toolkit
Toolkit/Guide Conducting Quality Improvement Sexually Transmitted Disease Services
Save Share

Welcome to the Toolkit

Chlamydia is the most commonly reported notifiable disease in the United States. In 2016, there were over 1.6 million cases of chlamydia reported to the Centers for Disease Control and Prevention (CDC). The highest chlamydia rates are among adolescent (ages 15–19) and young adult (ages 20–24) women. While usually asymptomatic, if left untreated, chlamydia infection in women can lead to pelvic inflammatory disease, a major cause of infertility, ectopic pregnancy, and chronic pelvic pain. Chlamydial infection also increases susceptibility to the transmission of HIV. Chlamydia is easily detected and, if identified, treatable with antibiotics.

The goal of this toolkit is to support an increase in Title X grantees' chlamydia screening rates. This toolkit supports improvement on the HEDIS chlamydia screening measure[®]: the percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

In This Toolkit:

- Welcome
- How To Use the Toolkit
- Assess Baseline Chlamydia Screening Rates and Practices
- Develop an Improvement Plan

<https://www.fpntc.org/resources/chlamydia-screening-toolkit>

DISCUSSION GUIDE Increase Chlamydia Screening in Family Planning Settings Introduction to the Chlamydia Screening Change Package



How to Use This Guide

Learning Objectives

Length

Materials

Format

Suggested Participants

Before You Start...

This guide is designed to support facilitation of an interactive learning session on how to **Increase Chlamydia Screening in Family Planning Settings: Introduction to the Chlamydia Screening Change Package**, whose purpose is to drive improvement on the **chlamydia screening performance measure**.

Facilitators should feel free to adapt and revise this guide. Facilitators may choose to:

- Convene staff from one or more clinics for a standing meeting (e.g., monthly) to discuss each Best Practice (in order or as needed) from the Chlamydia Screening Change Package. (See other Best Practice discussion guides.)
- Convene a one-time meeting with clinic staff about this topic.

By the end of the discussion, participants should be able to:

- Describe the **best practice recommendations for chlamydia screening as outlined in the Chlamydia Screening Change Package**
- Describe one tool available to help calculate and track the chlamydia screening rates at a service site
- Describe at least two strategies for increasing chlamydia screening in target populations

At least **60 minutes**, with more time for discussion as schedules allow. Example discussion questions are provided; facilitators can use them based on participant interest.

Chlamydia Screening Change Package: Summary of evidence-based recommendations for increasing chlamydia screening rates, strategies, case studies, tools, and resources

- PowerPoint Slides with Notes:** Slides with speaker notes and discussion questions
- Quality Improvement Tools (printed), including:**
 - Chlamydia Screening Performance Measure Calculator** (can be completed in advance)
 - Prioritization Matrix**

Discussions can be facilitated **virtually or in person**.

Staff from one or more family planning clinics. Involving multiple sites can facilitate peer-to-peer sharing. Having representation of clinical, administrative, and financial staff can help address system issues.

Participants should **calculate site-level performance** on the chlamydia screening performance measure using the Chlamydia Screening Performance Measure Calculator (if needed).

Using Normalizing and Opt-out Language for Chlamydia and Gonorrhea Screening

SAMPLE SCRIPT

Chlamydia (CT) and gonorrhea (GC) are the two most common notifiable diseases in the United States, and rates have increased in recent years.¹ Finding and treating infections in a timely manner is an effective way to limit the spread of infection and to prevent the long-term consequences of untreated infections in women: pelvic inflammatory disease, ectopic pregnancy and tubal infertility. This sample script is designed to help staff use normalizing and opt-out language to screen for CT/GC.

WHO SHOULD BE SCREENED? Centers for Disease Control and Prevention (CDC) Screening Recommendations for Chlamydia and Gonorrhea²

POPULATION	SCREENING RECOMMENDATION
Women	<ul style="list-style-type: none"> Sexually active women under 25 years of age Sexually active women aged 25 years and older if at increased risk (i.e., a new sex partner, more than one sex partner, sex partner with concurrent partners, or sex partner with a STD) Retest approximately 3 months after treatment
Pregnant Women	<ul style="list-style-type: none"> All pregnant women under 25 years of age Pregnant women, aged 25 and older if at increased risk Screen during the 3rd trimester for women under 25 years of age or at risk Pregnant women with chlamydial infection should have a test of cure 3-4 weeks after treatment and be retested within 1 month
Men	<ul style="list-style-type: none"> Consider screening young men in high prevalence clinical settings or in populations with high burden of infection (e.g., MSM) for chlamydia
Men who have Sex With Men	<ul style="list-style-type: none"> At least annually for sexually active MSM at sites of contact (urethra, rectum) regardless of condom use; every 3 to 6 months if at increased risk
Persons with HIV	<ul style="list-style-type: none"> For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter; more frequent screening if at risk

¹CDC Sexually Transmitted Disease Surveillance, National Overview of STD, 2012.
²CDC Screening Recommendations and Considerations Published in 2015 STD Treatment Guidelines.

NORMALIZING LANGUAGE

Use normalizing language when offering CT/GC screening to present screening as a routine part of a visit. When clinic staff use normalizing language, it helps clients feel that they are not being judged or singled out. Below are examples of how to offer CT/GC screening using normalizing language.

I talk to all of my patients about chlamydia screening. Untreated chlamydia can lead to infertility or the inability to have children.

To keep you healthy, I recommend we screen for common infections that come from sexual contact.

OPT-OUT LANGUAGE

Opt-out screening is an approach that presumes screening by default unless the client actively declines. Opt-out screening can be offered regardless of reason for visit (if there is not a contraindication to screening) or of the following:

We recommend a test for chlamydia and gonorrhea. If you've had these tests recently, I'd like to do that today. If not, I'd like to do that today.

We test everyone your age for chlamydia and gonorrhea. If you've had these tests recently, I'd like to do that today. If not, I'd like to do that today.

We ask all of our patients your age if they've had these tests recently. If you've had these tests recently, I'd like to do that today. If not, I'd like to do that today.



USING NORMALIZING AND OPT-OUT LANGUAGE CHLAMYDIA AND GONORRHEA SCREENING FOR WOMEN UNDER 25

We recommend a test for chlamydia and gonorrhea to everyone under 25. I'd like to do that today. Do you have questions or concerns?

CDC RECOMMENDATIONS

- Screen sexually active women < 25 years of age for chlamydia and gonorrhea.
- Screen women with self-collected vaginal swabs, urine sample, or provider-collected swabs.
- Retest approximately 3 months after treatment.



Sample Script and Palm Card

Training Guides: PowerPoint slide deck with Talking Points; Discussion Guide

Training Activity for Clinic Staff

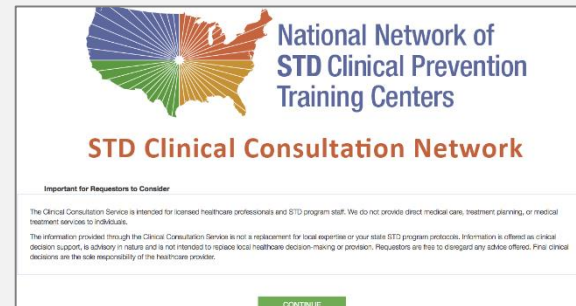




Questions?

Clinical questions?

www.STDCCN.org



Holly Howard, MPH

Holly.Howard@cdph.ca.gov

WRAP UP



Register Now!

Member early bird rate until Nov 8!



Registration open now!



**Nadine Burke
Harris, MD**
Surgeon General
of California



**Adam
Schickedanz, MD**
Pediatrician &
researcher, UCLA



**Michelle Rhone-
Collins**
Founding LIFT-
Los Angeles
Executive Director



Len Nichols
Policy professor,
George Mason
University



Ai-Jen Poo
ED, National
Domestic
Workers Alliance



Celinda Lake
Pollster &
political
strategist



Stacey Chang
Founder & ED,
Design Institute
of Health



Robin Wittenstein
CEO,
Denver Health



William York
Executive VP,
211 San Diego

Upcoming Dates

	M	T	W	Th	F
	October				
Oct 23 (12-1): DY14 Year End PRIME Data Review [link]	21	22	23	24	25
Oct 28 (12-1): QIP Leads Webinar	28	29	30	31	1
Oct 29 & 30: DHCS/PRIME PRIMEd Annual Learning Collaborative Event (Sac, CA)	November				
Nov 7 (12-1): PRIME Disparity Reduction – Progress to Date [link]	4	5	6	7	8
Nov 14(12-1): PRIME/QIP OH	11	12	13	14	15
Nov 18 (12-1): Hardwiring & Scaling PRIME QI Projects [here]	18	19	20	21	22

Reminder – feedback please!



How did we do?

What did you learn?

Do you have
suggestions for future
topics or content?

**PLEASE COMPLETE
OUR POP-UP SURVEY**