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Evidence-Based Strategies for Increasing Chlamydia and Gonorrhea Screening in Title X Settings

May 9, 2019

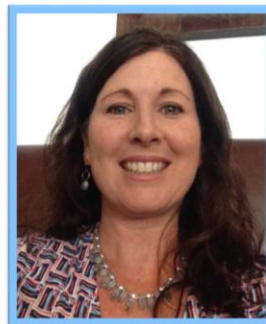


- Hello everyone and welcome to today's webinar, Evidence-Based Strategies for Increasing Chlamydia and Gonorrhea Screening in Title X Settings. This is Katie Quimby from the Title X Family Planning National Training Center and I'm very pleased that you are here joining us today.
- A few things before we begin. Everyone on the webinar today is muted, given the large number of participants. Please use the chat at the bottom left of your screen to ask questions at any time. We'll address all questions at the end of the presentation.
- The resources we will be talking about today are available on fpntc.org. Following today's webinar, we will also be posting a recording of the webinar, along with the slide deck and a transcript.



Holly Howard, MPH

Director, *National
Quality Improvement
Center*



- I'm thrilled to introduce our speakers for today's webinar. Holly Howard is the director of the CDC funded National Quality Improvement Center, where she works with a team of subject matter experts to design, conduct, and evaluate clinical quality improvement interventions and resources focused on supporting providers in implementing STD clinical care best practices.
- Holly additionally serves as the Chief of Health Promotion and Health Care Quality Improvement at the California Department of Public Health STD Control Branch where she has served for 18 years including over 10 years as the state's infertility prevention project coordinator. Over the last five years, Holly has served as the program director for a chlamydia screening quality improvement initiative in California.
- Towards the end of the webinar we'll also hear briefly from Jennifer Kawatu. A Woman's Health Nurse by training, Jennifer has worked for over two decades developing training and resources for Title X and serves as the clinical quality training consultant for the Family Planning National Training Center.
- With that, I'm going to turn it over to Holly to start today's webinar.

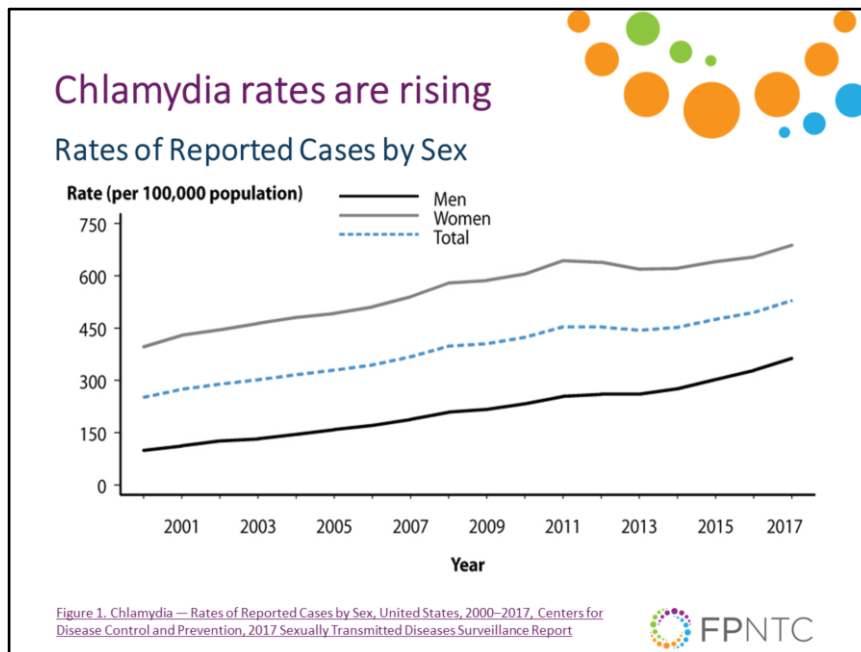
Today's Objectives

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

- Describe the current rates and trends of chlamydia and gonorrhea infections and screening
- Explain CDC's screening, treatment, and management recommendations
- Describe evidence-based implementation strategies for increasing screening
- Identify three FPNTC tools that are available to support Title X grantees in increasing screening in their networks



- Today, I look forward to talking to you about some best practices and implementation strategies for chlamydia and gonorrhea screening in Title X settings. Here, our objectives and roadmap for our talk today.
- I will start off with some quick highlights related to national rates and trends in chlamydia and gonorrhea infections and screening.
- I'll go over CDC's screening, treatment and management recommendations for both infections.
- And then for the majority of our time, I'll focus on sharing evidence-based implementation strategies for increasing screening rates.
- I'll then hand it back to Jennifer at the Family Planning National Training Center to share some fantastic tools that they have developed to support Title X grantees in increasing screening in their networks.



- To set the stage, it's no secret that we are seeing rising chlamydia rates across the country. These rates are increasing among both men and women. In some areas like my home state of California, these rates are higher than they have been during any time within the last 25 years.

Source:

Centers for Disease Control and Prevention. *Sexually Transmitted Disease Surveillance 2017*. Atlanta: U.S. Department of Health and Human Services; 2018.

https://www.cdc.gov/std/stats17/2017-STD-Surveillance-Report_CDC-clearance-9.10.18.pdf.

While some areas have
higher rates of chlamydia...

Rates of Reported Cases by County

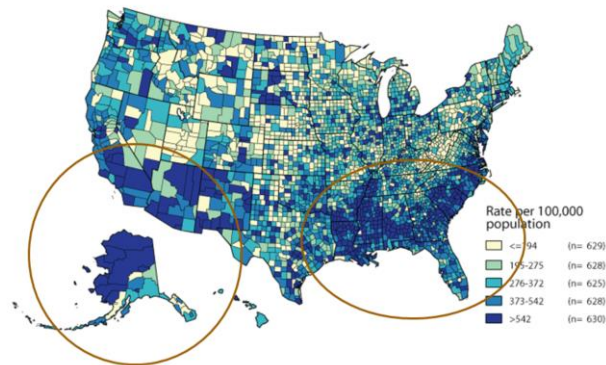


Figure 4. Chlamydia — Rates of Reported Cases by County, United States, 2000–2017, Centers for Disease Control and Prevention, 2017 Sexually Transmitted Diseases Surveillance Report

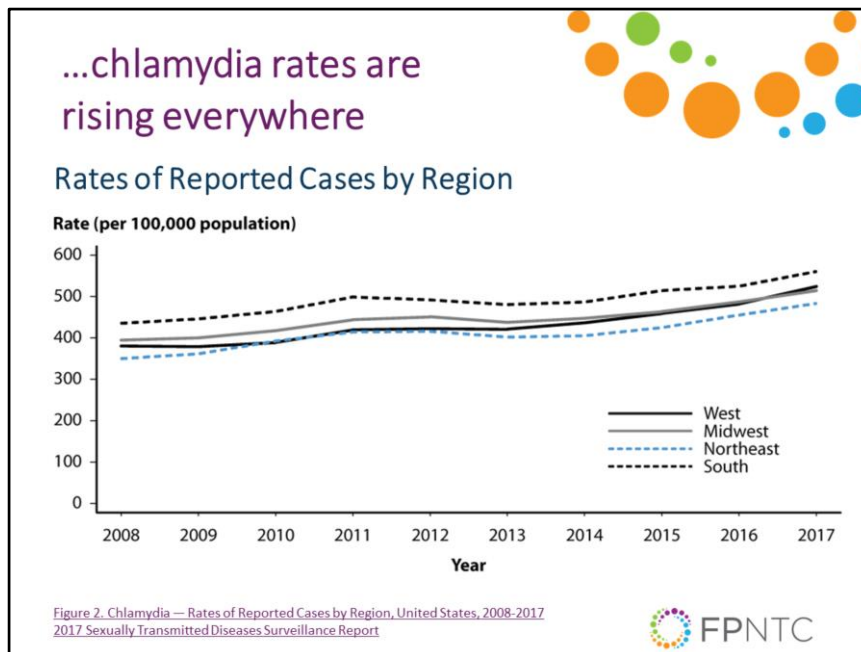


- In this slide, we're looking at aggregate rates of reported chlamydia cases between 2000 and 2017 by county with the light yellow color representing the lowest rates and the dark blue color representing the highest rates of chlamydia infection. We can see that there are geographic disparities in these rates.

Source:

Centers for Disease Control and Prevention. *Sexually Transmitted Disease Surveillance 2017*. Atlanta: U.S. Department of Health and Human Services; 2018.

https://www.cdc.gov/std/stats17/2017-STD-Surveillance-Report_CDC-clearance-9.10.18.pdf.



- But while some areas of the country experience higher rates of chlamydia, chlamydia rates are rising everywhere including within all four major regions of the country.

Source:

Centers for Disease Control and Prevention. *Sexually Transmitted Disease Surveillance 2017*. Atlanta: U.S. Department of Health and Human Services; 2018.

https://www.cdc.gov/std/stats17/2017-STD-Surveillance-Report_CDC-clearance-9.10.18.pdf.

Chlamydia disparities

Rates of Reported Cases by Age Group and Sex, 2017

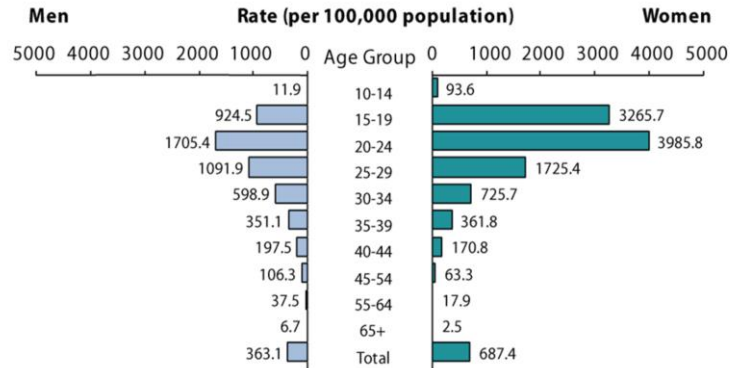


Figure 5. Chlamydia — Rates of Reported Cases by Age Group and Sex, United States, 2017
2017 Sexually Transmitted Diseases Report



- Chlamydia, as we know, is also not an equal opportunity player when it comes to age and sex.

Source:

Centers for Disease Control and Prevention. *Sexually Transmitted Disease Surveillance 2017*. Atlanta: U.S. Department of Health and Human Services; 2018.

https://www.cdc.gov/std/stats17/2017-STD-Surveillance-Report_CDC-clearance-9.10.18.pdf.

Chlamydia disparities

Rates of Reported Cases by Age Group and Sex, 2017

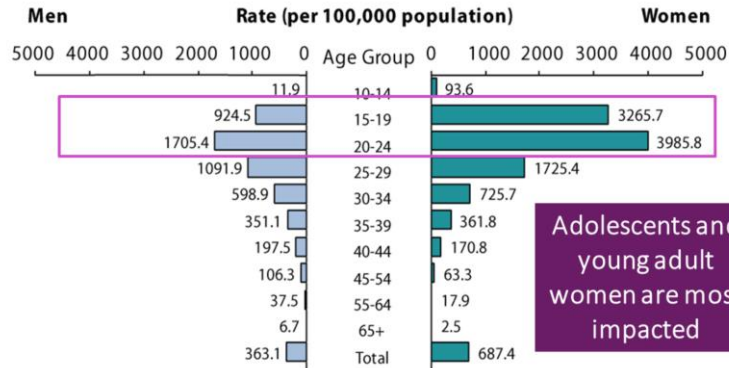


Figure 5. Chlamydia — Rates of Reported Cases by Age Group and Sex, United States, 2017
2017 Sexually Transmitted Diseases Report



Adolescents and young adult women are most impacted

- Young people are most impacted by these skyrocketing chlamydia rates and especially adolescent girls and young women, which you can see by looking at the incredible disparities in rates, accented within the pink box on the CDC graphic, which is showing U.S. rates of reported chlamydia cases, stratified by sex with men on the left in light blue and women on the right in green, and by age group with the ages getting older as you move down the graph.
- It is likely that since chlamydia often presents without clinical signs or symptoms and because we have clear screening recommendations specifically for women, reported cases such as those represented in this CDC graphic may reflect a disproportionate number of chlamydia infections identified through screening programs offered primarily to women.
- However, there is research evidence that demonstrates higher incidents of chlamydia among females, even when both sexes are screened universally and we have substantial evidence that demonstrates that chlamydia infection is strongly associated with younger age.

Source:

Centers for Disease Control and Prevention. *Sexually Transmitted Disease Surveillance 2017*. Atlanta: U.S. Department of Health and Human Services; 2018.

https://www.cdc.gov/std/stats17/2017-STD-Surveillance-Report_CDC-clearance-9.10.18.pdf.

Chlamydia disparities

Rates of Reported Cases by Race and Hispanic Ethnicity

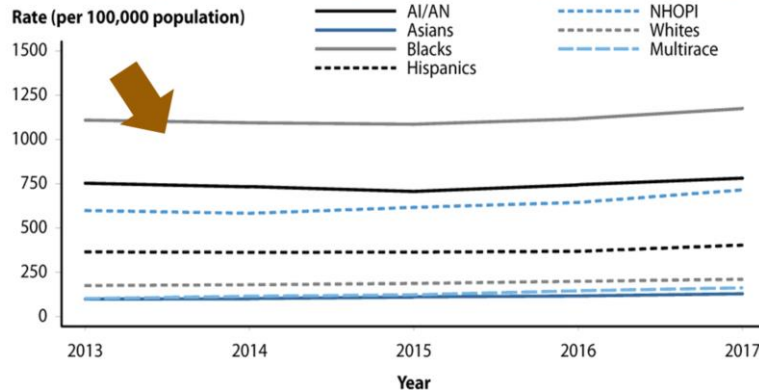


Figure 8. Chlamydia — Rates of Reported Cases by Race and Hispanic Ethnicity, United States, 2013–2017, 2017 Sexually Transmitted Diseases Report



- There is also great disparity in rates of chlamydia infections across races and ethnicities, with Black and African American communities experiencing a much higher burden of disease compared to other racial ethnic groups, a trend that has not been changing over time.

Source:

Centers for Disease Control and Prevention. *Sexually Transmitted Disease Surveillance 2017*. Atlanta: U.S. Department of Health and Human Services; 2018.

https://www.cdc.gov/std/stats17/2017-STD-Surveillance-Report_CDC-clearance-9.10.18.pdf.

Gonorrhea rates are also rising...

Rates of Reported Gonorrhea Cases by Sex

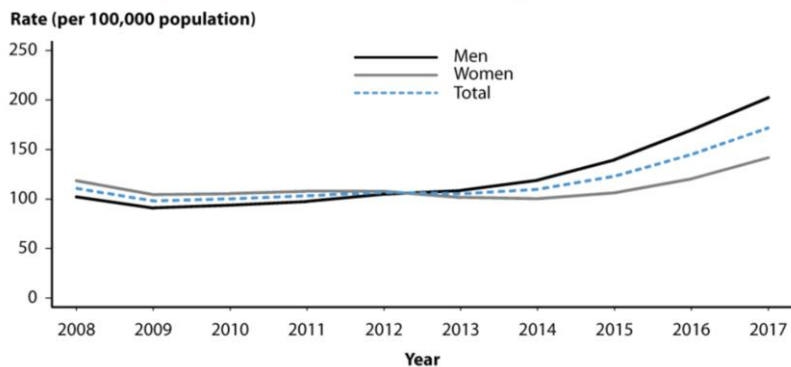


Figure 18. Gonorrhea — Rates of Reported Cases by Sex, United States, 2008–2017, 2017 Sexually Transmitted Diseases Report

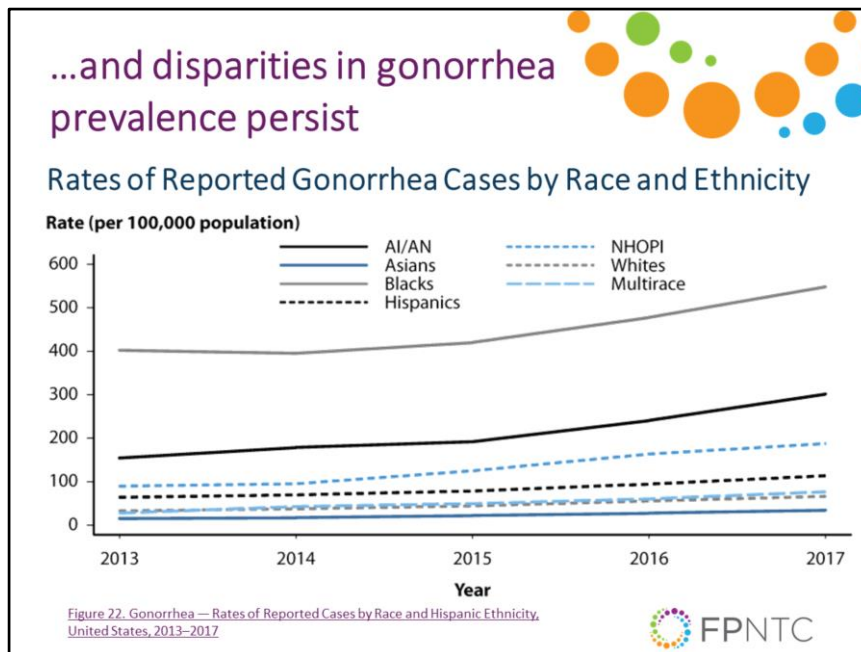


- Gonorrhea rates are also rising among both men and women but with this reversed trend compared to chlamydia when looking at rates by sex. This CDC graph is showing us reported gonorrhea cases from 2008 through 2017 and you can see that rates of reported cases among men surpass those among women some time in 2012. And also that reported cases in males are rising at a steeper rate than females.
- Gonorrhea tends to be more symptomatic in men versus women. So many of these reported cases among men are likely a reflection of diagnostic testing among men with symptoms. Gonorrhea cases among men also disproportionately represent men who have sex with men.

Source:

Centers for Disease Control and Prevention. *Sexually Transmitted Disease Surveillance 2017*. Atlanta: U.S. Department of Health and Human Services; 2018.

https://www.cdc.gov/std/stats17/2017-STD-Surveillance-Report_CDC-clearance-9.10.18.pdf.



- And we see the same disparities in rates of gonorrhea among racial ethnic groups as we saw with chlamydia with much higher reported rates among Blacks and African Americans. So while STD rates are surging everywhere, the burden of these infections are disproportionately impacting different communities and populations.
- So let's pause for just a minute from talking about national trends and rates and population impacts because I'd really like you to meet Jade. Jade is a 22 year old woman and student at the local technical college in your community. She comes into your clinic as a walk-in for contraception. She's started on Depo Provera using Quick Start and is encouraged to come back at a later date for a full well woman exam and labs.

Source:

Centers for Disease Control and Prevention. *Sexually Transmitted Disease Surveillance 2017*. Atlanta: U.S. Department of Health and Human Services; 2018.

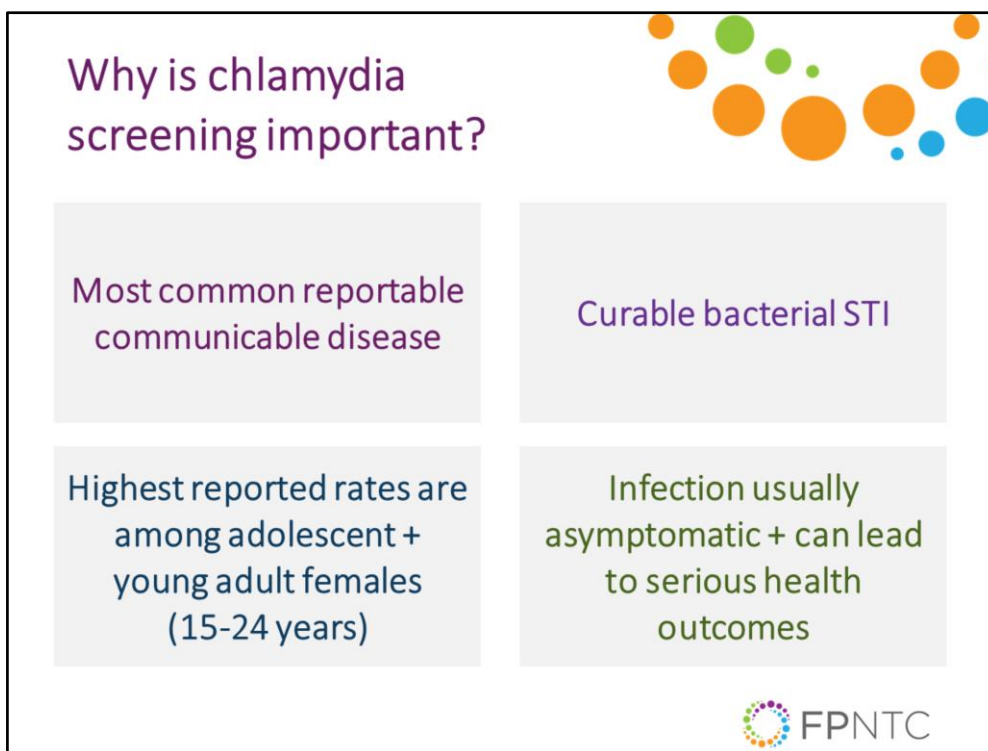
https://www.cdc.gov/std/stats17/2017-STD-Surveillance-Report_CDC-clearance-9.10.18.pdf.

Meet Jade

Jade is a 22-year-old female student at the local technical college. She comes to your clinic as a walk-in for contraception. She is started on Depo Provera using “Quick Start” and is encouraged to come back at a later date for an exam and labs.



- As we go through this talk today, let's think about Jade and many patients like her. And if we're missing opportunities to best serve them.



- All right. So back to chlamydia. Why does it matter? Why is chlamydia screening important? Chlamydia continues to be the most commonly reported national notifiable disease in the United States by far with 1.7 chlamydia infections reported to CDC in 2017 and climbing each year.
- It is not just the most commonly reported STD but wins the award over any notifiable diseases reported overall. Can you guess what the second most commonly reported notifiable disease is in the nation? Gonorrhea.
- Plus, we know this is an underestimate as a large number of chlamydia and also gonorrhea cases are not reported because most people with these infections do not have symptoms and do not seek testing. Additionally, we should note that the population most commonly served by your Title X networks, adolescents and young adult women aged 15 to 24, have the highest chlamydia rates. Also, chlamydia is an easily and inexpensively curable bacterial infection. If we can identify these infections, we can quickly and effectively treat them.
- But because the vast majority of chlamydia infections are asymptomatic and yet still can silently progress to more severe health outcomes, routine screening is considered the cornerstone in preventing chlamydia related adverse health outcomes and slowing the rising rates of infection.

Chlamydia and gonorrhea can cause serious adverse outcomes

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

FPNTC

- What are the serious adverse health outcomes we are concerned about with chlamydia? Women infected with chlamydia or gonorrhea can develop Pelvic Inflammatory Disease or PID which in turn can lead to reproductive system morbidity such as tubal factor infertility, ectopic pregnancy and chronic pelvic pain. Symptomatic PID occurs in 10 to 15% of females with unrelated chlamydia.
- Tubal scarring from PID can cause infertility in 20% of women. Ectopic pregnancy in 9% and chronic pelvic pain in 18%. And chlamydia and gonorrhea infections are also both known to increase the risk of HIV transmission amongst females and males.
- Women infected with *C. trachomatis* or *N. gonorrhoeae* can develop PID, which, in turn, can lead to reproductive system morbidity such as ectopic pregnancy and tubal factor infertility. Symptomatic PID occurs in 10%–15% of females with untreated chlamydia^{1,2}. Among women with PID, tubal scarring can cause infertility in 20% of women, ectopic pregnancy in 9%, and chronic pelvic pain in 18%³.
- In women, untreated chlamydia can spread into the uterus or fallopian tubes and cause pelvic inflammatory disease (PID). Symptomatic PID occurs in about 10 to 15 percent of women with untreated chlamydia.^{2,3} However, chlamydia can also cause subclinical inflammation of the upper genital tract (“subclinical PID”). Both

acute and subclinical PID can cause permanent damage to the fallopian tubes, uterus, and surrounding tissues.

- The vague symptoms associated with chlamydial and gonococcal PID cause 85% of women to delay seeking medical care, thereby increasing the risk of infertility and ectopic pregnancy.^{4, 5}
- Untreated chlamydia may increase a person's chances of acquiring or transmitting HIV—the virus that causes AIDS.⁶
- About 80%–90% of chlamydial infections and up to 80% of gonococcal infections in women are asymptomatic. These infections are detected primarily through screening.⁷ The symptoms associated with PID are vague so 85% of women with PID delay seeking medical care, thereby increasing the risk for infertility and ectopic pregnancy.⁸ Data from a randomized controlled trial of chlamydia screening in a managed care setting suggest that such screening programs can reduce the incidence of PID by as much as 60%.⁹

End Notes:

¹Haggerty CL, Gottlieb SL, Taylor BD, Low N, Xu F, Ness RB. Risk of sequelae after *Chlamydia trachomatis* genital infection in women. *The Journal of infectious diseases* 2010;201 Suppl 2:S134–55.

²Oakeshott P, Kerry S, Aghaizu A, et al. Randomised controlled trial of screening for *Chlamydia trachomatis* to prevent pelvic inflammatory disease: the POPI (prevention of pelvic infection) trial. *BMJ (Clinical Research ed)* 2010;340:c1642.

³<http://www.cdc.gov/std/pregnancy/STDFact-Pregnancy.htm>

⁴Center for Disease Control and Prevention. STD Surveillance, 2011: Women and Infants. <http://www.cdc.gov/std/stats/womenandinf.htm>

⁵Hills SD, Wasserheit JN. Screening for Chlamydia—A Key to The Prevention of Pelvic Inflammatory Disease. *New England Journal of Medicine*. 1996;334(21):1399–1401.

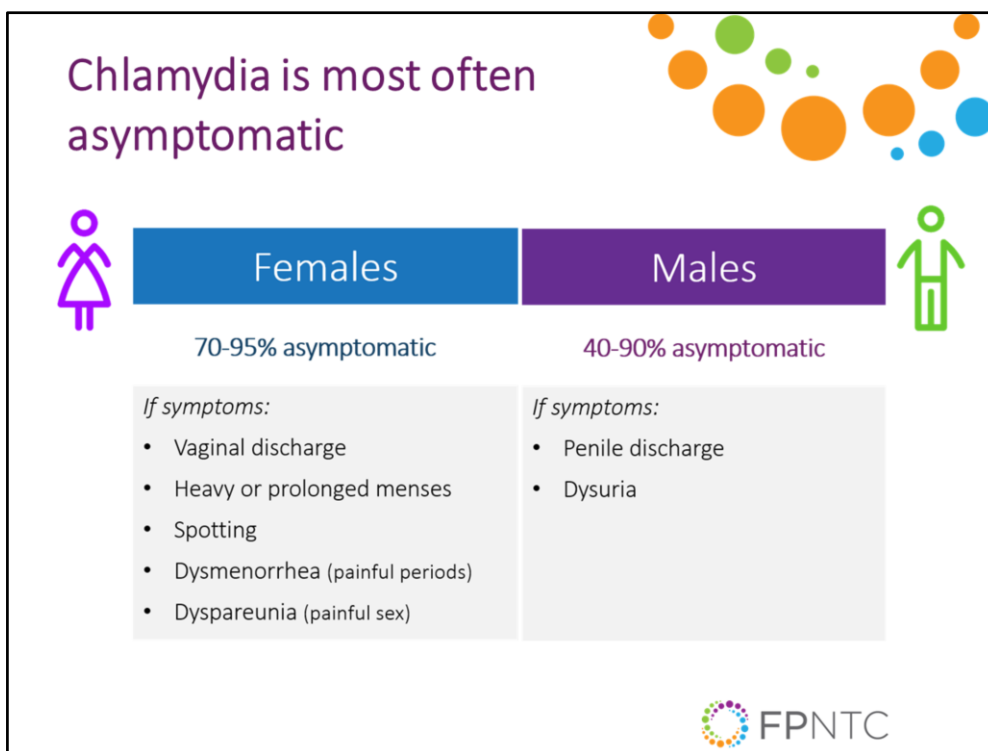
⁶Fleming DT, Wasserheit JN. From epidemiological synergy to public health policy and practice: the contribution of other sexually transmitted diseases to sexual transmission of HIV infection. *Sexually Transmitted Infections* 1999;75:3-17.

⁷Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2011.

<https://www.cdc.gov/std/stats/archive/Surv2011.pdf>.

⁸Ibid

⁹Ibid



- Chlamydia is most often asymptomatic but if girls and women do have symptoms, they may include vaginal discharge, heavy or prolonged periods, spotting in between periods, painful periods or pain with sexual intercourse. Boys and men might experience penile discharge or report painful urination. But we know from research that an estimated 70 to 95% of chlamydia infections in females are asymptomatic and 40 to 90% of infections in males are asymptomatic.
- Estimates of the proportion of chlamydia-infected people who develop symptoms vary by setting and study methodology; two published studies that incorporated modeling techniques to address limitations of point prevalence surveys estimated that only about 10% of men and 5–30% of women with laboratory-confirmed chlamydia infection develop symptoms.¹
- Based on this information, up to 90% of males are asymptomatic and up to 70–95% of females are asymptomatic.

End Notes:

¹Centers for Disease Control and Prevention. *Chlamydia Detailed Fact Sheet*.

<https://www.cdc.gov/std/chlamydia/stdfact-chlamydia-detailed.htm>

Routine screening is recommended by national experts

| | |
|---|---|
| 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)
- * CDC 2015 STD Screening Guidelines
- * USPSTF Recommendations for STI Screening



- For all of these reasons, routine screening for chlamydia is recommended by numerous national medical and public health bodies, including the American Academy of Pediatrics, American Academy of Family Physicians, ACOG, CDC and the US Preventive Services Task Force. Many of these recommendations are aligned, recommending routine, at least annual screening for all sexually active girls and women aged 24 and under or older if they are at increased risk. And boys and men in high prevalence settings or at increased risk.
- The American Academy of Pediatrics (AAP) – Bright Futures recommends all sexually active youth annually.
- The American Academy of Family Physicians (AAFP) recommends sexually active females ≤24 yrs. annually & others at increased risk.
- The American Congress of Obstetricians & Gynecologists (ACOG) recommends sexually active females ≤24 yrs. annually & others at increased risk.
- The Centers for Disease Control & Prevention (CDC) recommends sexually active females ≤24 yrs. annually, and adolescent males in high prevalence areas.
- The US Preventive Services Task Force (USPSTF) recommends sexually active females ≤24 yrs. annually & others at increased risk.

Sources:

Tanski, S, Garfunkel, LC, Duncan, PM, and Weitzman, M, eds. *Performing Preventive Services: A Bright Futures Handbook*. American Academy of Pediatrics.

<https://brightfutures.aap.org/materials-and-tools/PerfPrevServ/Pages/default.aspx>.

Centers for Disease Control and Prevention. *Screening Recommendations Referenced in the 2015 STD Treatment Guidelines and Original Recommendation Sources*.

<https://www.cdc.gov/std/tg2015/screening-recs-2015-std-tx-guidelines.pdf>.

U. S. Preventive Services Task Force. *Final Recommendation Statement: Chlamydia and Gonorrhea Screening*.

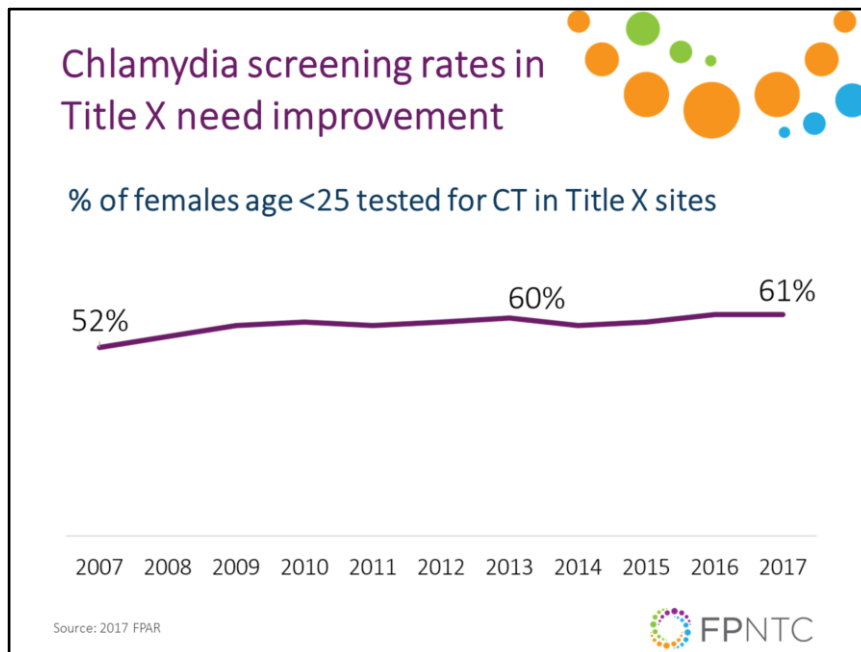
<https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/chlamydia-and-gonorrhea-screening>

Jade returns

Jade comes every 3 months for a Depo shot – although she is late one month and has a pregnancy test done. It is negative and she gets another shot. She is again encouraged to come in for “an annual exam.”



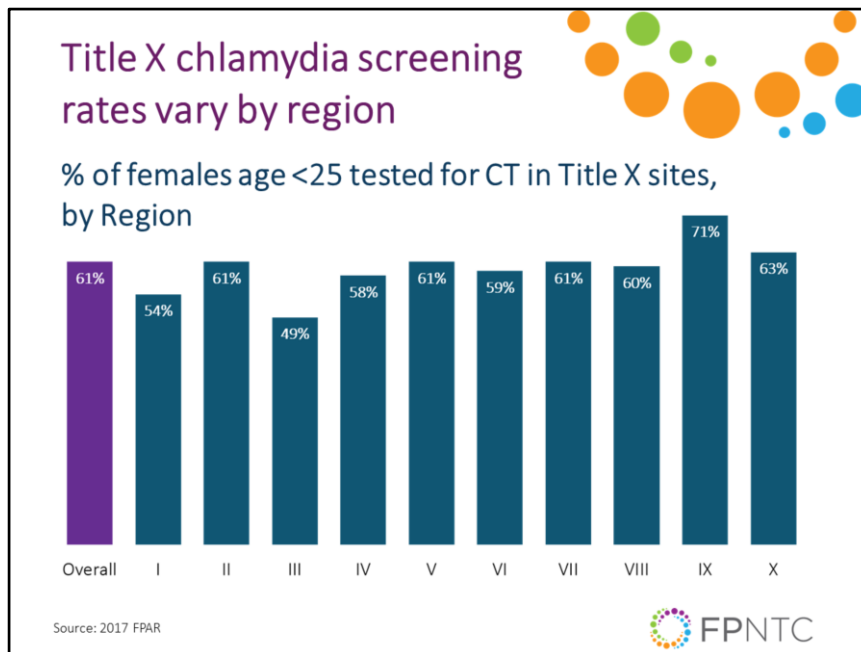
- Ah yes, but here is Jade again. She's coming into your clinic regularly now, every three months for her Depo shot. One month she comes late and has a pregnancy test done as a precaution. It's negative and so she gets another shot. Again, she's encouraged to come back for an annual exam.
- While we are doing a pretty good job at helping to take care of Jade's contraception needs, I'm concerned about some missed opportunities in her comprehensive sexual health care and the potential implications these care gaps may have for Jade, including some that put her future reproductive health at risk.



- This slide shows us a trend line for the percent of females under age 25 who are tested for chlamydia in Title X sites on average across the country from 2007 through 2017. These are FPAR data. So we know these are Family Planning clients and therefore, we know presumably they are sexually active. And they are being seen in our Title X networks, setting that are already clearly committed to providing quality sexual and reproductive health care. And yet, we are still seeing significant gaps in chlamydia screening rates without very much improvement over time.

Source:

Fowler, CL, Gable, J, Wang, J, and Lasater, B. (2018, August). *Family Planning Annual Report: 2017 National Summary*. Research Triangle Park, NC: RTI International.
<https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2017-national-summary.pdf>.



- Here we can see that these chlamydia screening rates in Title X settings do vary somewhat by region. Now, most regions have it right around the national as per average. There are few that fall significantly lower and one that performs significantly better than average but still has room to improve.

Source:

Fowler, CL, Gable, J, Wang, J, and Lasater, B. (2018, August). *Family Planning Annual Report: 2017 National Summary*. Research Triangle Park, NC: RTI International.
<https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2017-national-summary.pdf>.

Jade has PID

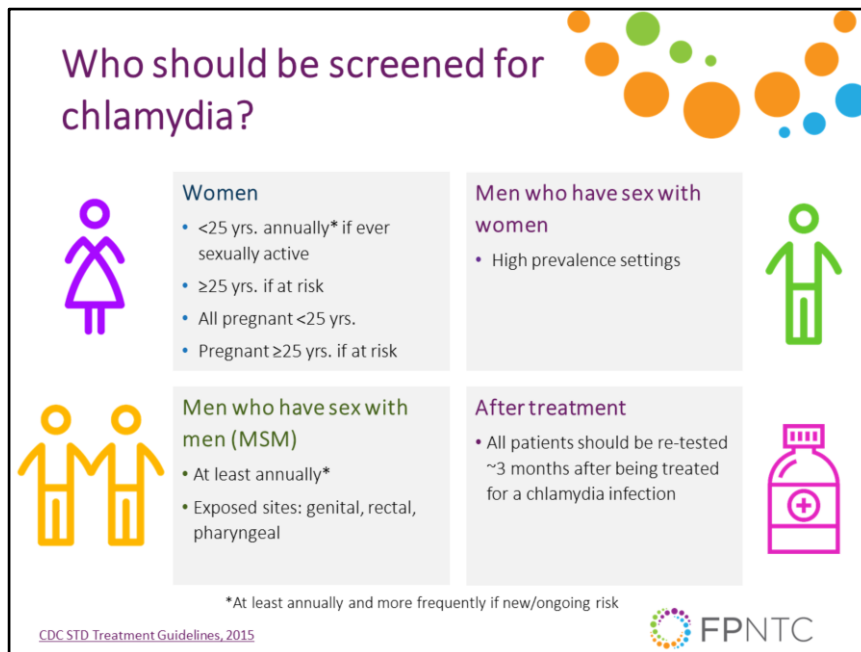
Jade returns to the clinic complaining about her vaginal discharge and pelvic pain. During a pelvic exam, the nurse practitioner sees signs of infection and is concerned about possible pelvic inflammatory disease (PID).



Could this have been prevented?



- Hi Jade, it's good to see you again. I'm so sorry you're experiencing vaginal discharge and pelvic pain today. Our nurse practitioner will perform a pelvic exam to see what she can determine. The NP detects some ooze from Jade's os and diagnoses cervicitis. Jade also shows signs on exam of cervical motion tenderness. Oh no, it looks like Jade may have PID. Could this have been prevented?



- CDC has specific recommendations for who should be screened for chlamydia at least annually and more frequently if indicated by risk. This includes young sexually active women under age 25 as we have noted and women 25 and older if considered at risk and I'll come back to how we determine risk in a minute.
- Also, all pregnant women under age 25 should be screened at their first prenatal visit. They should be re-screened in the third trimester if indicated by risk. Pregnant women aged 25 and older should also be screened at their first prenatal visit if that is determined a need because of their risk.
- Among men who have sex exclusively with female partners, screening is recommended in clinical settings serving populations of young males with a high prevalence of chlamydia infections for example adolescent clinics, correctional facilities and STD clinics. Screening is recommended for men who have sex with men at least annually in anatomical sites, specifically genital, rectal and pharyngeal sites if exposed.
- Re-screening, also called retesting, for chlamydia and gonorrhea is recommended for all patients who have been diagnosed and treated for chlamydia or gonorrhea infection approximately three months after treatment.
- CDC and the US Preventive Services Task Force have specified risk factors for chlamydia and gonorrhea, based on gender and age as we have discussed and also

note racial disparities.

Source:

Centers for Disease Control and Prevention. *2015 Sexually Transmitted Diseases Treatment Guidelines*.

<https://www.cdc.gov/std/tg2015/default.htm>.

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

Sex Partners

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

Special Populations

- Incarcerated populations
- Military recruits
- Public STD clinic patients

Racial Disparities

- Black and Hispanic populations have higher rates vs. Whites

Behavior

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

STD History

- Past STDs
- Concurrent STDs

[Screening for Chlamydia and Gonorrhea: Clinical Summary of USPSTF Recommendation](#)



- Risk factors for chlamydia and gonorrhea related to sex partners include having a recent new partner, for example within the last three months, having more than one sex partner for example within the past year, having a sex partner who has been diagnosed with an STD and having a recent sex partner where the patient suspects may have had concurrent sex partners.
- Behavioral factors noted include inconsistent condom use, substance use and exchanging sex for money or drugs. Special populations with demonstrated higher rates of infection include people who are incarcerated, military recruits and public STD clinic patients. And having been diagnosed with an STD in the past year or having a current STD diagnosis, for example syphilis, are also strongly associated with chlamydia and gonorrhea infection.
- Clinicians should consider the communities they serve and may wish to consult with local public health authorities for guidance on further identifying groups at increased risk in their area.

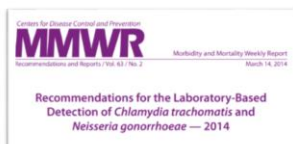
Source:

U. S. Preventive Services Task Force. *Clinical Summary: Chlamydia and Gonorrhea: Screening.*

<https://www.uspreventiveservicestaskforce.org/Page/Document/ClinicalSummaryFin>

[al/chlamydia-and-gonorrhea-screening](#)

What are the recommended specimen types for chlamydia and gonorrhea?



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, 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

- Not FDA-approved for rectal or pharyngeal specimens but remain the preferred testing method over culture


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

- CDC recommends nucleic acid amplification tests or NAATs for detection of genital, rectal or oropharyngeal CT and GC infections. So because rectal and oropharyngeal lab tests are not yet FDA-approved, lab validation testing is needed before this testing can be offered. Many of the major lab companies have already gone through these internal validations so you can check with local facilities to see if they offer this testing.
- CDC notes that the most optimal specimen test for asymptomatic infections include first catch urine for men and self-collected vaginal swabs for women. The first catch urine for women is also highly recommended.

Source:

Centers for Disease Control and Prevention. *Recommendations for the Laboratory-Based Detection of Chlamydia trachomatis and Neisseria gonorrhoeae – 2014.*

<https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6302a1.htm>.



If Positive

1. Treat the Patient

CHLAMYDIA

Recommended regimens (non-pregnant):

- ❖ Azithromycin 1 g orally in a single dose
- ❖ Doxycycline 100 mg orally twice daily for 7 days

Recommended regimens (pregnant*):

- ❖ Azithromycin 1 g orally in a single dose

GONNORHEA

Recommended regimens (uncomplicated infections of cervix, urethra and rectum):


- ❖ Ceftriaxone 250 mg IM in a single dose PLUS
- ❖ Azithromycin 1g orally in a single dose

Alternative regimens (if ceftriaxone unavailable):

- ❖ Cefixime 400 mg orally in a single dose PLUS
- ❖ Azithromycin 1 g orally in a single dose

*Test of cure at 3-4 weeks only in pregnancy

CDC 2015 STD Treatment Guidelines



- So, we have screened our patients. If their tests come back positive, the first step, of course, is to ensure their timely and adequate treatment. Here are the recommended treatment regimens for chlamydia. For non-pregnant women Azithromycin one gram orally in a single dose which can be directly observed, or a seven day regimen of Doxycycline 100 milligrams orally twice a day. For pregnant women Azithromycin one gram orally is also recommended.
- Gonorrhea, because of considerable concerns about growing antibiotic resistance, currently requires a dual treatment regimen that includes both Ceftriaxone 250 milligrams IM [intramuscular] in a single dose plus Azithromycin one gram orally in a single dose. It is important to note that these are intended to be taken and given at the same time. So being able to dispense of Azithromycin on site at your health center is a facilitator to adhering to this recommended dual concurrent treatment regimen.
- An alternative regimen for chlamydia treatment, for example if Ceftriaxone is unavailable, includes Cefixime 400 milligrams orally in a single dose plus Azithromycin one gram orally in a single dose, both taken at the same time. This is a regimen used in expedited patient therapy for sex partners which I'll talk about in a minute.

Source:

Centers for Disease Control and Prevention. *Sexually Transmitted Diseases Treatment Guidelines, 2015*.

<https://www.cdc.gov/std/tg2015/tg-2015-print.pdf>.

If Positive [⊕]

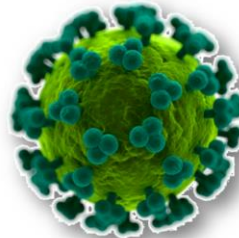
2. Screen for concurrent STDs

All patients diagnosed with chlamydia or gonorrhea should be tested for other STDs, including:

Syphilis

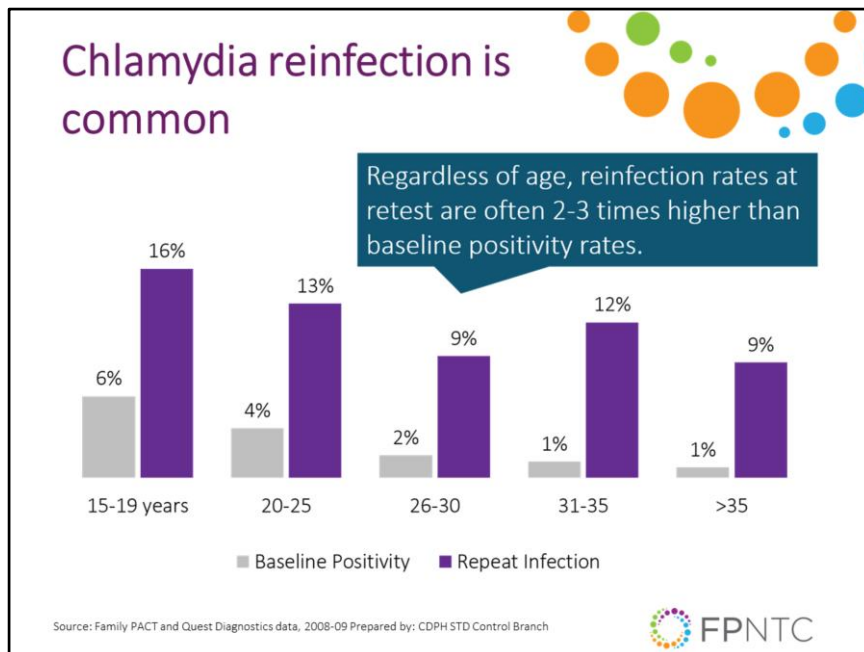


HIV

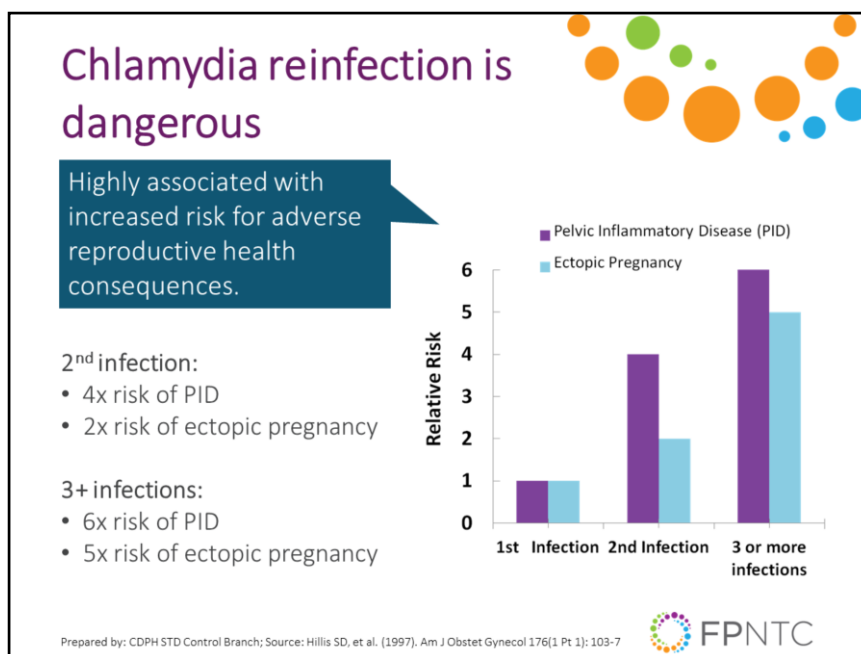


 FPNTC

- For patients who test positive for chlamydia or gonorrhea, it is also incredibly important to screen for concurrent STDs including syphilis and HIV. National rates of syphilis among women of reproductive age have increased by 143% over the last four years and following in parallel, reported cases of congenital syphilis have increased by 156%, reaching a 20 year high, and is considered to be at epidemic proportions in some areas of the country.
- Co-infection with a concurrent STD is a risk factor for syphilis. So screening your patients for syphilis if they have tested positive for chlamydia or gonorrhea is incredibly important.



- Reinfection with chlamydia and gonorrhea in the months after initial diagnosis is very common. This slide shows baseline chlamydia infection rates in light gray bars by age group in the California state Family Planning program in 2008 through 2009, compared to the reinfection rates, the dark purple bars, among those patients with initial infections who are retested within the year following.
- While initial infection with chlamydia is highly associated with younger age, reinfection rates at retest were two to three times higher than their baseline positivity, regardless of age.



- Chlamydia reinfection is also very dangerous and highly associated with increased risk for adverse reproductive health consequences. Having a second chlamydia infection increases a woman's risk for developing PID by four fold and doubles the risk of ectopic pregnancy, compared to having only one chlamydia infection. A third chlamydia infection pushes your risk of PID up to six fold with a five-fold risk of ectopic pregnancy.

Source:

Hills, SD, Owens, LM, Marchbanks, PA, Amsterdam, LF, and MacKenzie, WR. Recurrent Chlamydial Infections Increase the Risks of Hospitalization for Ectopic Pregnancy and Pelvic Inflammatory Disease. *American Journal of Obstetrics Gynecology*, 1997, 176(1 Pt 1), 103-107.

If Positive⁺

3. Treat sexual partners

First-Line Option: **Concurrent Patient-Partner Therapy**

Performing a clinical evaluation of recent/current sex partners at patient's STD treatment visit

- Ask patient to bring his/her partner to treatment visit -- can be effective for one primary partner

Also Effective: **Expedited Partner Therapy (EPT)**

Treating a sex partner of a patient diagnosed with an STD without first examining the partner

- *Patient-Delivered Partner Therapy (PDPT)* is EPT via patient delivery of the treatment -- Offering prepackaged medication is most effective; giving Rx is also an option
- Offer routinely to patients for partner(s) who cannot be promptly treated

CDPH STD Control Branch, *Best Practices for the Prevention and Early Detection of Repeat Chlamydial and Gonococcal Infections*: Effective Partner Treatment and Patient Retesting Strategies for Implementation in California Health Care Settings, June 2011.



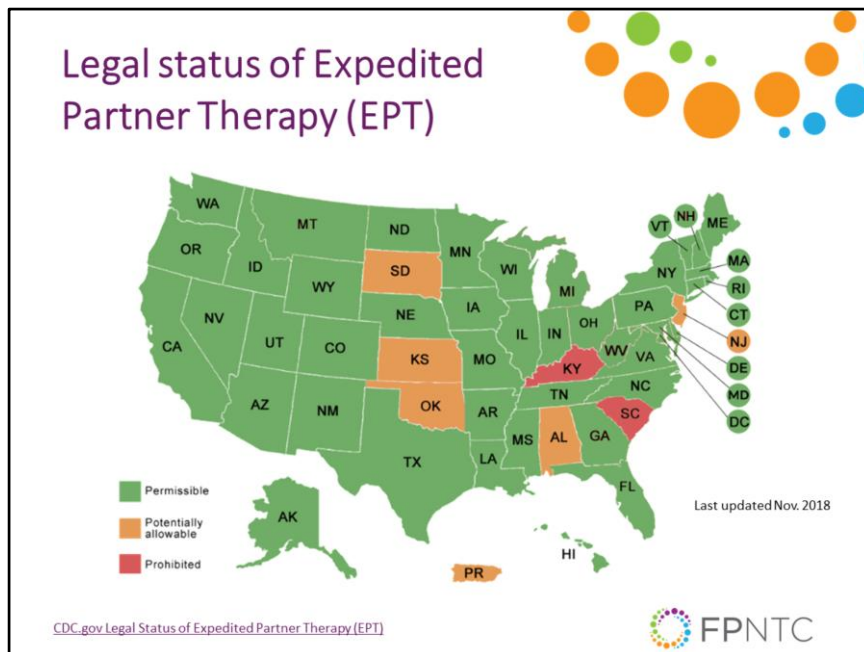
- One of the most effective ways of reducing a person's risk for reinfection is by ensuring their sex partners also get treated. The first line gold standard recommendation for partner treatment is concurrent patient partner therapy, sometimes lightly referred to as BYOP or Bring Your Own Partner.
- In this scenario, the patient is asked to bring his or her current or main partner with them to their treatment visit to allow for clinical evaluation of the partner as well as presumptive treatment for the partner and risk reduction counseling. This strategy ensures that both the patient and partner are treated at the same time which also starts their clock together for delaying their return to sex until seven days after treatment is concluded. Concurrent patient partner therapy or BYOP seems to be an effective option for patients with one primary sex partner.
- Also very effective for ensuring partner treatment is expedited partner therapy or EPT which is the treating of sex partners of a patient diagnosed with an STD without first examining the partner. Patient-delivered partner therapy or PDPT is a common method of EPT, offering the patient pre-packaged medication to give to their partners is the most effective PDPT modality. Providing extra prescriptions to give to the patient to give to his or her partners is also an option. PDPT is something that can be routinely offered to patients for partners who cannot be promptly treated.

- These are two evidence-based partner treatment options that have been shown to be effective at reducing reinfection rates in the index patient.

Source:

California Department of Public Health Sexually Transmitted Disease Control Branch.
*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.*

[https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/Best
_Practices_for_Preventing_RepeatCT_Inf.pdf](https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/Best_Practices_for_Preventing_RepeatCT_Inf.pdf)



- EPT is currently legal in 43 states and potentially allowable in five others plus Puerto Rico. It is only expressly prohibited in two states. A number of state and large city public health department STD programs have figured out mechanisms for helping eligible clinical settings access PDPT medications. I recommend that you check in with your state and city program to learn what options may exist in your area.

Source:

Centers for Disease Control and Prevention. Legal Status of Expedited Partner Therapy (EPT).

<https://www.cdc.gov/std/ept/legal/default.htm>

If Positive ⊕

4. ReScreen (“retest”)

Retesting is recommended for ALL patients who have tested positive for chlamydia or gonorrhea ~3 months after treatment...or opportunistically at next visit

- Timing: need to wait at least 3 weeks after treatment to re-test for chlamydia with NAAT because of risk for false positives (continued presence of nonviable organisms)
- Retesting is especially important for adolescents; high prevalence of repeat infection



- Finally, because reinfection is so common and dangerous, if your patient tests positive for chlamydia and/or gonorrhea, CDC recommends re-screening, also called retesting, for all patients approximately three months after their treatment or opportunistically, the very next time they present at your health center for care. It is important that the retest occur more than three weeks post-treatment to reduce their risk of not detecting lingering non-viable organisms and giving a false positive result. Retesting is especially important for adolescent patients where repeat infection rates are exceptionally high.

Screening + management – in summary:



Screen for chlamydia + gonorrhea

If screen is positive for either:



Screen for syphilis + HIV



Treat patient + Treat partners

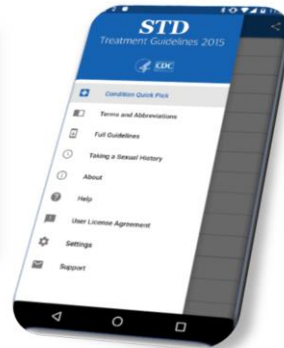
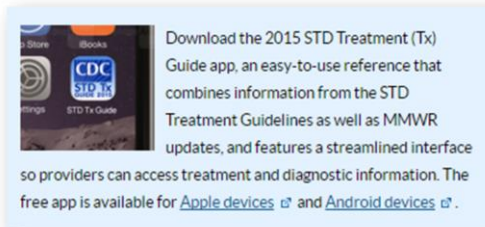


ReScreen again in 3 months



- CDC recommendations for chlamydia and gonorrhea screening and management in summary includes screening for chlamydia and gonorrhea at least annually and if positive, for either or both infections, screening for syphilis and HIV, treating the patient, treating the partners and re-screening the patient again in three months.
- Because we're a fun-loving bunch in the STD world, we sometimes use the funny little mnemonics for this that sounds a bit like a dance step and it goes like this, screen, screen, treat, treat, screen. We can call it the CTGC five step boogie.

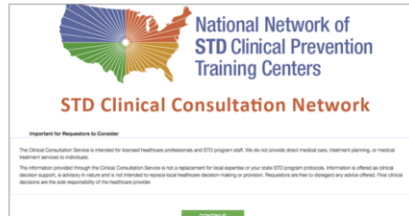
Hey! There's an app for that...



- CDC has translated their STD Treatment Guidelines into a handy reference app you can download to your Apple or Android device. Get it for free from your app store.

STD Clinical Consultation Network (STDCCN)

- Provides STD clinical consultation services to healthcare providers nationwide (1-5 days depending on urgency)
- Your consultation request is linked to a CDC-funded STD Prevention Training Center's expert faculty



<http://www.STDCCN.org>



- And if you're in need of STD clinical consultation, the National Network of STD Clinical Prevention Training Centers offers a free consultation service called the STD Clinical Consultation Network or STDCCN which is a man and woman powered by CDC funded STD Prevention Training Center expert clinical faculty. Please don't hesitate to use this service for clinical advice about your STD clients.

<http://www.STDCCN.org>



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FAMILY PLANNING
NATIONAL TRAINING CENTER

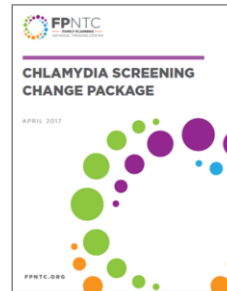
What to do about it?
Best Practice
Implementation Strategies
for Improving
Chlamydia Screening



- Okay. Now that we have covered what the CDC CT and GC screening recommendations include and why they are important, let's spend the rest of our time focusing on the how. How can your Title X health centers implement these best practices? What are some of the implementation strategies that are associated with success for screening programs?

Chlamydia Screening Change Package

1. Include chlamydia screening as a part of **routine** clinical preventive care
2. Use **normalizing and opt-out language**
3. Use the least invasive, high-quality, recommended **laboratory technologies** available
4. Utilize diverse payment options to **reduce cost as a barrier**



- The *Chlamydia Screening Change Package* It is a compendium of recommendations for increasing chlamydia screening developed by the FPNTC as a guide for chlamydia screening quality improvement at Title X sites.
- The four primary recommendations are to:
 1. Include chlamydia screening as a part of routine clinical preventive care for women 24 years and younger, women >24 who are at increased risk, and men at increased risk.
 2. Use normalizing and opt-out language
 3. Use the least invasive, high-quality, recommended laboratory technologies available for chlamydia screening, with timely turnaround.
 4. Utilize diverse payment options to reduce cost as a barrier for the client and the facility.

Source:

Chlamydia Screening Change Package.

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

Best Practice 1.

Include chlamydia screening as a part of routine clinical preventive care for women 24 years and younger, women >24 who are at increased risk, and men at increased risk.

- Have a written policy and protocol
- Establish standing orders and a standardized workflow
- Utilize a team approach to care
- Share screening data with staff and providers
- Utilize service delivery approaches that increase efficiency



Best Practice 1 is to include chlamydia screening as part of routine clinical preventive care for women 24 years and younger, women older than 24 who are at increased risk, and men at increased risk.

- Because chlamydia screening is recommended for sexually active women 24 years and younger, regardless of risk profile, staff can begin to prepare for chlamydia screening for women in this age range even before they arrive at the clinic.
- Screening can be offered with an “opt-out” approach, meaning women can refuse screening if they don’t want it, but the default scenario is that you prepare for screening.
- Include chlamydia screening in all visits, not just preventive health visits, and ideally all primary care visits - not just “family planning” visits.
- Include assessment of the need for screening as a part of pregnancy test and emergency contraceptive counseling visits as well.

The primary strategies that drive this best practice recommendation are to:

- Have a written policy and protocol for screening all sexually active women 24 years and younger for chlamydia and gonorrhea as part of preventive health care, women 24 years or older who are at increased risk, and men at increased risk.
- Establish standing orders and a standardized workflow.

- . Utilize a team approach to increase chlamydia screening rates. Meaning, engage all staff in identifying clients who should be screened—not just the provider.
- . Share screening data with staff and providers.
- . Utilize service delivery approaches to increase efficiency (to free up time for increased screening).

Best Practice 2.

Use normalizing and opt-out language to explain chlamydia screening to all women 24 years and younger, women >24 at increased risk, and men at increased risk.

- Avoid asking questions like, *"Do you want to be tested for chlamydia today?"*
- Use opt-out language such as, *"I recommend a test for chlamydia to all my clients under 25."*
- Include all staff in training
- Educate clients on the importance of screening, and how to reduce their risk for STDs



- Best practice number two is to use normalizing and opt-out language to introduce chlamydia screening to sexually active women. Normalizing language decreases the chance that clients will feel judged and frames this service simply as part of standard care. The primary strategies to drive this best practice recommendation are to avoid asking closed questions such as "Do you want to be tested for chlamydia today?," that put the patient in a position of having to decide if they think they are at risk. Share sample scripts and have staff practice role playing with opt-out language such as phrases like, "I recommend testing for chlamydia and gonorrhea to all my clients under age 25."
- Include all staff in training. Staff with client contact should receive training on preferred and acceptable specimen collection options, current screening criteria and national recommendations and potential sequelae of untreated chlamydia, local chlamydia prevalence and how to respond to positive results.
- Educate your clients to help them understand the importance of screening, including sharing how common chlamydia is among young people, how rates are rising and how most people don't know when they have an infection because there are often no symptoms. Also, share with them the risk for complications if infections remain undetected. And help clients understand how they can reduce their risks for STDs, including the importance of using condoms in addition to their

effective method for contraception.

- Don't forget to similarly educate your clients who test positive for chlamydia or gonorrhea about the importance of getting their partners treated and of their three month retesting visit, given the very high rates and dangerous reproductive health consequences associated with reinfection.



- So here is a great success story from Michigan, highlighting the use of best practices one and two. Amy Peterson from the Michigan Department of Health's STD program partnered with her state's Title X networks to successfully improve their FPAR chlamydia screening rates between 2015 and 2016 by double digits among 15 to 24 year old females Title X clients.
- She did this by first highlighting Michigan Title X's low FPAR chlamydia screening rates to capture people's attention within a formal STD update training she was asked to provide for Michigan Title X providers. She then helped key informant interviews and focus groups for Title X providers and staff to ask them to help her identify missed opportunities for screening among their Family Planning client visits and she distilled what she learned from these sessions into three system intervention change ideas and solicited 13 volunteer Title X health centers who agreed to pilot test one of these three intervention changes over a period of about six months.

Michigan's Success Story



Michigan Department of Health and Human
Services' Title X Implementation Strategies:

1. *Routinely included CT/GC
screening for pregnancy-test-
only and EC-only visits*



- The three interventions they tested were: 1. routinely including chlamydia and gonorrhea screening within pregnancy-test-only and EC-only visits; 2. bundling chlamydia and gonorrhea screening within Title X and annual visits, using an opt-out approach - for example one clinic developed a standard postcard that they began to hand out to all clients at their Title X annual visits, which listed out all the services you will receive today as part of your annual exam. And then the provider would go over the list with the client and ask if they had any concerns about the services being provided.

Michigan's Success Story



Michigan Department of Health and Human Services' Title X Implementation Strategies:

1. *Routinely included CT/GC screening for pregnancy-test-only and EC-only visits*
2. *Bundled CT/GC screen within Title X initial + annual visits using an opt-out approach – e.g., postcard summarizing “all services you will receive today as part of your annual exam”*



- Because chlamydia and gonorrhea screening was included on this list, bundled into this list of services and not simply called out or asked about, this normalized screening is just a standard part of the annual Title X visit, reducing client refusals to the screen.

Michigan's Success Story



Michigan Department of Health and Human Services' Title X Implementation Strategies:

1. *Routinely included CT/GC screening for pregnancy-test-only and EC-only visits*
2. *Bundled CT/GC screen within Title X initial + annual visits using an opt-out approach – e.g., postcard summarizing “all services you will receive today as part of your annual exam”*
3. *Standing order for routine urine collection implemented for all Title X clients; submission of specimen if no CT/GC screen in past 12 months*



- The third intervention they tested was creating standing orders for routine urine collection implemented for all Title X client visits with submission of specimen for chlamydia and gonorrhea screening if no screen had occurred within the past 12 months. So somebody would look up and see if there was a screen in the chart over the past 12 months and if none, they would recommend putting forward that urine for screening. Again, the provider would share the standard practice with the client when in the room and ask about any concerns but it was another spin on the opt-out approach with a more proactive specimen collection and submission protocol.

Michigan's Title X CT Screening Success

Success in Pilot Clinics

- Screening rates increased from 45% to 89% by 6 months post-intervention
- CT positivity remained high: 8.0% pre- to 7.5% post-intervention

CDC STD Prevention Conference 2018; prepared by Amy Peterson, MDHHS



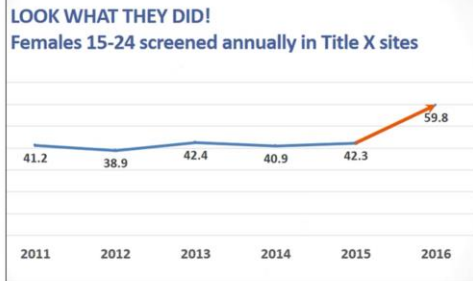
- Within the Title X sites that piloted one of these three interventions, their screening rates increased from 45% to 89% by six months. They only tested one each with the biggest jump, an increased jump right up to 85% occurring right at the gate within the first three months and then just increasing more gradually and sustaining over time. The chlamydia positivity remained high in these settings, pre and post intervention in spite of the broader group of clients being screened which means that approximately twice the number of chlamydia cases were being detected, cases that previously would have been missed.

Michigan's Title X CT Screening Success

Success in Pilot Clinics

- Screening rates increased from 45% to 89% by 6 months post-intervention
- CT positivity remained high: 8.0% pre- to 7.5% post-intervention

Success across Entire MI Title X Network



CDC STD Prevention Conference 2018; prepared by Amy Peterson, MDHHS



- And even though only 13 of the 100 or so Michigan Title X sites piloted this intervention formally, there were a lot of opportunities for these sites and the STD program to share results back with the broader Title X network, which led to other sites initiating some of the same strategies, and this resulted in a big uptake in the Michigan Title X chlamydia screening rates, the first real improvement in the state's rates after many years of status quo.

Best Practice 3.

Use the least invasive, high-quality, recommended laboratory technologies available for chlamydia screening, with timely turnaround.

- Establish routine clinic flow processes for routine screening
- Procure lab services with timely turnaround
- Make all screening options available, including self-collected vaginal swabs
- Establish a recall system to retest clients 3 months after treatment



- Best practice 3 is to use the least invasive, high-quality recommended laboratory technologies available for chlamydia screening, with timely turnaround. This means making all optimal urogenital specimen types available, including self-collected vaginal swabs for women.
 - Historically, chlamydia and gonorrhea specimens were collected during pelvic exams at “annual” preventive health visits, at the same time pap testing was being conducted. But now recommendations for pelvic exams and pap testing have changed, and fewer pelvic exams are being done.
 - Test technologies now allow for screening without a pelvic exam.
 - 2015 CDC STD Treatment Guidelines cite that chlamydia and gonorrhea urogenital infections can be diagnosed in women by testing first-catch urine or collecting swab specimens from the endocervix or vagina.
 - CDC recommends a self-collected vaginal swab as the recommended sample type.
 - The primary strategies that drive this best practice recommendation are to:
 - Establish routine clinic flow processes and systems
 - Make all screening options available, including self-collected vaginal swabs
 - Procure lab services with timely turnaround
 - Establish a recall system to retest clients three months after treatment

in the case of a positive result

Best Practice 3. Success Story



Nevada Health Centers

"We used to have women in the waiting room just waiting until they had to pee. Now, with vaginal swabs, either the provider does it during their exam, or they can do it themselves..."



- So here is another Title X chlamydia screening success story, this one is from Nevada and highlights the use of best practice number three. In order to make testing as easy for women as possible and increase their screening rate, Nevada health centers introduced vaginal swabs for chlamydia screening. They adjusted their workflow to include this new test technology and worked through implementation challenges. One front-line staff person said, "We used to have women in the waiting room, just waiting around until they had to pee. Now, with vaginal swabs, either the provider does it during their exam or they can do it themselves, no matter what and they're much happier about that. No more waiting around with a full bladder." Having the Chief Medical Officers buy in and rolling out the new process at an all staff meeting helped them with this transition.

Patient Instructions



University of Washington STD Prevention Training Center Resources
To order, please email aradford@uw.edu



- The University of Washington STD Prevention Training Center is happy to provide free, high-quality prints of our pharyngeal, rectal, and vaginal self-testing visual aids for your clinic.

<http://depts.washington.edu/uwptc/index.html>

To order, please send an email and include the quantity of each size and type desired with your shipping address to:

aradford@uw.edu

Best Practice 4.

Utilize diverse payment options to reduce cost as a barrier for the client and the facility.

- Ensure organizational policy is in line with Title X program requirements
- Ensure client confidentiality
- Bill third parties when possible
- Provide insurance eligibility screening
- Develop strategies to pay for safety-net screening services



- Best practice 4 is to “utilize diverse options to reduce cost as a barrier for the client and facility”, because we never want cost to be the reason someone doesn’t get screened – if they should be screened.
- So the recommendations are to:
 - First, ensure your organizational policy is in line with Title X program requirements – such as make sure you are using your sliding fee scale and following the other guidelines that help make sure services are affordable,
 - Second, bill third-parties when possible, but also make sure systems are in place to ensure client confidentiality (and it’s always a good practice to provide insurance application assistance to help clients get the coverage they’re eligible for),
 - And, develop strategies to pay for safety net screening services – for clients that remain uncovered or unwilling to use their coverage. So, this might be utilization of grant funding, coordination with the state STD program, and so on.
- The bottom line is that we do not want cost to be a barrier.

What about Jade?

What could we do differently next time?

- Routinely include CT/GC screening in all visits, even quick-starts
- Routinely bundle CT/GC screening with pregnancy testing
- Standing order: collect urine at all Title X visits; submit if no screen in past 12 months
- Check for last annual exam – if none in past 12 months, schedule



- Ah, Jade, what about Jade. Remember Jade? What can we do differently next time to ensure that chlamydia and gonorrhea screening does not slip through the cracks for clients like Jade. Think about your own setting and how you might close the clinical gaps we've experienced with Jade given your clinic systems and flow. Here are some recommendations, based on the best practices and implementation strategies already discussed.
- One idea is to routinely integrate chlamydia and gonorrhea screening into all Title X visits, even quick starts. Also, specifically routinely bundle chlamydia gonorrhea screening within pregnancy testing as you are already collecting urine specimen that can be split and used for both tests. You could set up standing orders as they did in Michigan to collect urine at all Title X visit, look up whether a screen occurred during the past 12 months and after an opt-out framed brief discussion with the client, submit the specimen for screening if there was no screen or if the client had a positive test during the previous year. And always a good practice, check for the patient's last annual well woman exam and if none has occurred during the past 12 months, take the time to schedule it with her while she is at your clinic instead of simply encouraging her to come back.

Emma, Primary Care Visit

- Emma is an 18-year-old patient at your clinic coming in for her annual well check. She is not currently a Title X client.
- Emma comes into the visit with her mother.
- How do we know if Emma needs a CT/GC screen?



- Before I finish up today, I just want to introduce you to one more patient. This is Emma. Emma is an 18 year old, coming to your clinic for her annual primary care well check. She is not currently a Title X client. She comes to the visit with her mom. How can we know if Emma needs chlamydia and gonorrhea screening?

Emma, Primary Care Visit

Routinely assess sexual activity

- National medical associations recommend assessment of sexual activity as a standard part of routine care:
- Starting in adolescence
- In an age-appropriate manner
- At least annually



Source: CDC, AMA, AAP, ACOG, AMFP



- One important step is to assess whether or not Emma is sexually active. Routine assessment of sexual activity is recommended by national medical associations as a standard part of primary health care. These are organizations, including the American Academy of Pediatrics Bright Futures, recommends that this assessment start during early adolescence, in an age-appropriate way and that it occur at least annually.
- All of these organizations also recommend some amount of private time between the patient and provider, separate from mom or dad or siblings or any friends that the patient may have brought with them to their visit. This ensures that the provider has an opportunity to discuss any sensitive issues confidentially with the patients, including the sexual activity assessment.

Emma, Primary Care Visit

- If Emma is identified as sexually active:
- Initiate comprehensive sexual and reproductive health education and services as part of her primary care visit:
- Including CT/GC screening



- If Emma is identified as sexually active, you want to ensure you initiate comprehensive sexual and reproductive health education and services as part of her primary care visit including chlamydia and gonorrhea screening.

Source: CDC, AMA, AAP, ACOG, AMFP

STD Clinical QI Resource Library

Quality Improvement Resources

| Image | Title | Summary | Topics | Resource Type | Download File |
|-------|---|---|--|-----------------|---------------|
| | Assessment alone Time Policy Letter | Hand this out to adolescents to let them know what to expect during their visit. | Assessment-friendly environment, Minor consent and confidentiality | Letter | Word |
| | Chlamydia Screening Protocol | Use this protocol to train staff on the chlamydia screening 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 |
| | Medication Assistant Script for Sensitive Conversation Barriers during Alone Time | Use this script to train clinic staff that head alone time with an adolescent on how to start conversations about sensitive topics. | Assessing sexual activity, Chlamydia screening | Clinic script | Word |

[National Quality Improvement Center](https://californiaptc.com/national-quality-improvement-center/)

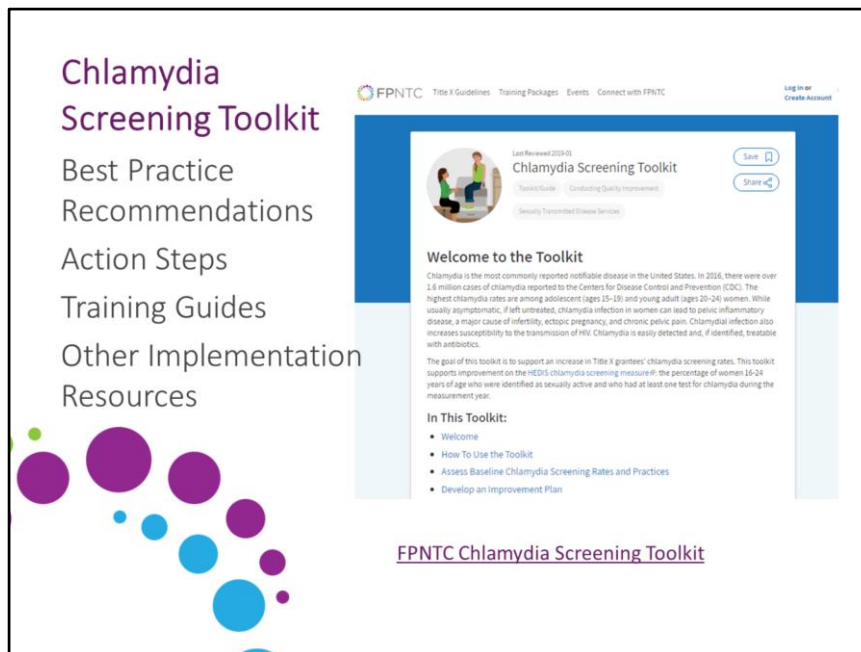
FPNTC

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

- The CDC funded National STD Quality Improvement Center has developed an STD Clinical QI Resource Library where you can search and download editable implementation resources such as job aids, tools, scripts, sample protocols, patient facing materials et cetera to help your practice implement STD clinical best practices.
- “At this point, I’d like to turn it over to Jennifer Kawatu, Clinical Consultant for the Family Planning National Training Center, to review a few FPNTC resources that are designed to support Title X staff in increasing screening rates, in addition to the Change Package which we already discussed.”

National Quality Improvement Center URL:

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



- So now that we've been talking about all of that, it's time now to talk about some of the changes you might want to make and about implementation. So we just want to make sure that you know about the Family Planning National Training Center chlamydia screening toolkit and all of the tools and resources that we have to support implementation of the best practices that Holly talked about today for increasing screening at Family Planning sites.

Source:

Chlamydia Screening Toolkit.

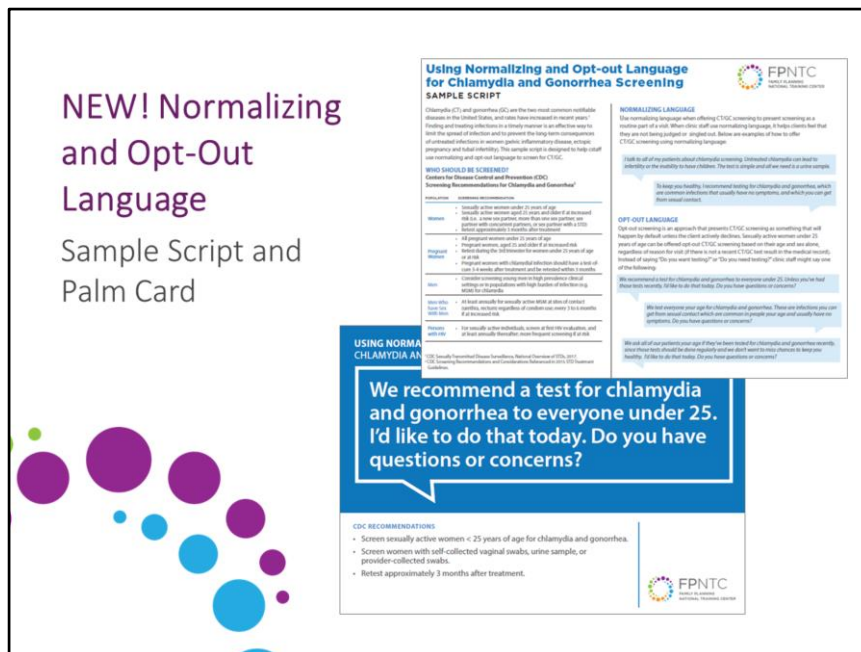
<https://www.fpntc.org/search?keys=chlamydia+screening+toolkit>

Training Guides

For each Best Practice Recommendation:
PowerPoint Slide Deck with Talking Points
Discussion Guide

| DISCUSSION GUIDE | |
|---|--|
| Use Normalizing and Opt-Out Language to Explain Chlamydia Screening to Sexually Active Women 24 Years and Younger | |
| Chlamydia Screening Change Package: Best Practice 2 | |
| |  |
| How to Use This Guide | <p>This guide is designed to support facilitation of an interactive learning session on about how to Use Normalizing and Opt-Out Language to Explain Chlamydia Screening to Sexually Active Women 24 Years and Younger (Best Practice 2) from the Chlamydia Screening Change Package, whose purpose is to drive improvement on the Chlamydia screening performance measure.</p> <p>Facilitators should feel free to adapt and revise this guide. Facilitators may choose to:</p> <ul style="list-style-type: none"> 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. |
| Learning Objectives | <p>By the end of the discussion, participants should be able to:</p> <ul style="list-style-type: none"> Explain the benefits of using an opt-out approach to chlamydia screening for sexually active women 24 years and younger Describe at least two examples of opt-out and normalizing language to promote chlamydia screening Identify at least two strategies to increase staff comfort in normalizing language related to chlamydia screening |
| Length | At least 45 minutes, with more time for discussion as schedules allow. Example discussion questions are provided; facilitators can use them based on participant interest. |
| Materials | <ul style="list-style-type: none"> 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 |
| Format | Discussions can be facilitated virtually or in person . |
| Suggested Participants | 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. |
| Before You Start... | Participants should calculate site-level performance on the chlamydia screening performance measure using the Chlamydia Screening Performance Measure Calculator (if needed). |

- So included in the toolkit are training guides for training staff in your networks directly. Either you can use them by webinar or on site in person. And basically, they're editable PowerPoint presentations with talking points and with a discussion guide and facilitation questions. So you can use these, you can add to them, you can shorten them, you can make them your own but hopefully, they'll be helpful to you and help you get started so that you can train your networks.



- Then we have another couple of brand new job aids that we're rolling out and the intervention in the learning collaboratives that we've done and much of the work that we've done with the Title X networks. In this work, we've found that the intervention that had the single biggest impact on screening rates in Family Planning sites was using that opt-out language as Holly discussed.
- So because of that and the big impact that this seems to have, we developed a couple of job aids that you can use in the clinic sites, so you can post these in the clinic, you can have them on a desk or one of them can be slipped into a lab coat or brought around. And it has reminders about the screening recommendations as well as sample language to use that normalizing and opt-out approach to offering screening. So there is both the one pager. On the screen, you can see at the top, there is a one pager with more information, pretty comprehensive. We call that the sample script. And then there is a greatly abbreviated version, a palm card. And that just has the very basic information, just kind of a reminder, a visual cue to remind folks about the importance of screening and how to ask in that opt-out way.

Sources:

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

Sample Script.


<https://www.fpntc.org/resources/using-normalizing-and-opt-out-language-chlamydia-and-gonorrhea-screening-sample-script>.

Using Normalizing and Opt-out Language for Chlamydia and Gonorrhea Screening:
Palm Card.

<https://www.fpntc.org/resources/using-normalizing-and-opt-out-language-chlamydia-and-gonorrhea-screening-palm-card>.


NEW! Normalizing and Opt-Out Language

Training Activity for Clinic Staff



DISCUSSION GUIDE
Using Normalizing and Opt-out Language for Chlamydia and Gonorrhea Screening:
Training Activity for Clinic Staff

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| How to Use This Training Activity Guide | This training activity is designed to build the confidence of clinic staff to use normalizing and opt-out language for chlamydia and gonorrhea CT/GC screening. Using normalizing and opt-out language is an evidence-based approach to increasing screening rates, as described in the Chlamydia Screening Change Package. |
| Learning Objectives | By the end of the training activity, participants should be able to: <ul style="list-style-type: none"> • Use normalizing language when discussing CT/GC screening with clients. • Offer CT/GC screening to clients using an "opt-out" approach. |
| Length | At least 60 minutes, with more time for discussion as schedules allow. |
| Materials | <ul style="list-style-type: none"> • Handout 1: Using Normalizing and Opt-out Language for Chlamydia and Gonorrhea Screening: Sample Script • Handout 2: Chlamydia and Gonorrhea Screening Case Scenarios • Using Normalizing and Opt-out Language for Chlamydia and Gonorrhea Screening: Role Card (optional) • Markers and something to write on that all participants can see (e.g., flip chart paper, whiteboard or blackboard) |
| Format | This activity should be conducted in person . |
| Suggested Participants | Clinic staff who discuss CT/GC screening with clients, including clinical staff (physicians, nurse practitioners, physician assistants, nurse), medical assistants, health educators, family planning counselors, etc. |
| Before You Conduct the Training Activity... | <ul style="list-style-type: none"> • Review the Chlamydia Screening Change Package and Chlamydia Screening Toolkit to become familiar with the best practice recommendations to increase CT/GC screening. • Introduce the concept of normalizing and opt-out language with clinic staff. The Using Normalizing and Opt-out Language to Explain Chlamydia Screening: Role Card and Training Guide can be used to facilitate a discussion with staff about the rationale, benefits, recommendations, and strategies for implementation of normalizing and opt-out language. • Calculate and share CT/GC screening rates of the clinic and individual providers. Discuss with staff how the clinic's rate compares with Title X national rate. Consider using the Chlamydia Screening Calculator and Gonorrhea Screening Calculator to calculate and visualize the data. |



FPNTC Opt-Out training activity

- And finally, to help make sure that this normalizing and opt-out language really gets used, we know it's helpful to practice and gain confidence in the ways that you're going to say something, especially when you're saying something new and especially when it's replacing an old way of doing things. So it may not be the way that all staff have been talking about chlamydia and gonorrhea screening in the past, so we've developed a training activity to help just practice and get confident using a new approach. So this is a case-based role play training activity and there are instructions, there is a handout and a sample script. So you can use these to help train front-line staff on the implementation of how to use this opt-out and normalizing language to offer chlamydia screening. Like we said, it's really had a big impact on screening rates and it's been really impactful. So we hope that this will help you all spread that across the network as we discussed.

FPNTC Opt-Out Training Activity URL:


<https://www.fpntc.org/resources/using-normalizing-and-opt-out-language-chlamydia-and-gonorrhea-screening-training>



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Clinical questions?

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