



**FPNTC**  
FAMILY PLANNING  
NATIONAL TRAINING CENTER

## From Chlamydia Screening Best Practices to Successful Implementation: *Lessons from the Field*

May 8, 2018



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Megan Hiltner:

Hello everyone. We're excited to have you all with us. This is Megan Hiltner from the Title X Family Planning National Training Center, and I'm pleased to welcome you all to today's webinar: From Chlamydia Screening Best Practices to Successful Implementation.

From June to November of 2017, nine Title X grantees participated in the Chlamydia Screening Learning Collaborative to increase chlamydia screening rates in their networks. Our webinar today will cover information about chlamydia screening best practices and quality improvement strategies that led to the grantees' success. A few grantees who participated in the collaborative will also share specific improvement strategies and results of their efforts on the webinar too.

A few things before we begin. You all should have received a copy of the slides in the reminder that was emailed to registered participants yesterday. We'll post the slides from today's webinar on [FPNTC.org](http://FPNTC.org) along with a recording of today's webinar, the slide deck, and a transcript by early next week. We encourage all of you to use those resources. They're great tools to also help you train your networks.

Please use the chat box on the left corner of your screen to ask any questions at any time during the webinar. At the end of the presentation, we'll ask questions that were submitted

by chat, and we will get to those questions after the speakers complete their remarks.

So let's get started. I'd like to introduce our speakers for today. First is Jennifer Kawatu, and she is a nurse with a public health background who is part of the Family Planning National Training Center team. She has begun working on women's healthcare and quality improvement for almost 20 years, including the past, working on STD prevention initiatives such as the CDC's infertility prevention project on STD TAC and now the FPNTC.

Jennifer and I worked along with Lisa Schamus to facilitate the FPNTC's Chlamydia Screening Learning Collaborative, which is what we will be sharing more with you about today. In addition, with us today are Miss Jayna Gray. She's the director of program at the Missouri Family Health Council. Miss Latheria Charleston, the grant and budget coordinator with the Florida Department of Health. And Miss Tonia Walden, the senior community health nurse supervisor with the Florida Department of Health. They'll say more about themselves when they share their stories.

So with that I'll turn it over to you, Jennifer, for the presentation.

## Objectives

By the end of today's webinar, you should be able to:

- Identify at least three best practices from the Chlamydia Screening Change Package
- Describe at least three quality improvement strategies to improve chlamydia screening
- List at least two tools to conduct quality improvement efforts to improve chlamydia screening

Jennifer Kawatu:

Great. Thanks, Megan.

As Megan said, today we hope to talk about some of the best practices from the Chlamydia Screening Change Package and the Learning Collaborative. We will be describing some quality improvement strategies to increase chlamydia screening, and want to share some tools to conduct quality improvement efforts to improve chlamydia screening. That's what we're going to try to do today.

## Why Chlamydia Screening?

Chlamydia is the most commonly reported notifiable disease in the U.S.

- Almost 1.6 million cases of chlamydia reported to the CDC in 2016—the highest number of annual cases of any condition ever reported to CDC.
- Chlamydia is more prevalent among adolescent (15 to 19) and young adult (20 to 24) women.

If left untreated, chlamydia infection in women can lead to pelvic inflammatory disease.



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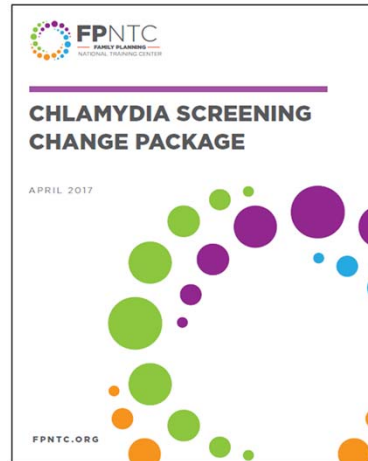
Let's first just remind ourselves why chlamydia screening is so important. In 2016, there were almost 1.6 million cases of chlamydia reported to the CDC, and this is the highest number of annual cases of any condition actually ever reported to the CDC, so reported cases of chlamydia is actually on the rise, and the rates have been going up and causing a great deal of concern.

Chlamydia is, the highest rates are among adolescents 15 to 19, young women, and young adults, so around 20 to 24. These are the folks who are the most vulnerable and most susceptible to the impacts of an untreated infection. So, while a chlamydia infection is usually asymptomatic, if left untreated, chlamydia infection can lead to pelvic inflammatory disease or PID, which is a major cause of infertility. It can cause ectopic pregnancy, and chronic pelvic pain. And chlamydia infection also increases susceptibility to the transmission of HIV.

Risks of infertility and ectopic pregnancy, increased risks of HIV are serious consequences of an untreated chlamydia infection. But, as we said, chlamydia is often asymptomatic, which is why screening for chlamydia is so, so important. And it is, if detected, it is easily treatable with antibiotics, so it's really a perfect disease, using the public health model, of something that we really should be focused on screening for. It lends itself well to universal screening. Well, not universal, but widespread screening.

## Chlamydia Screening Change Package

- Best practice recommendations
- Rationale
- Strategies
- Suggested evaluation measures
- Tools and resources



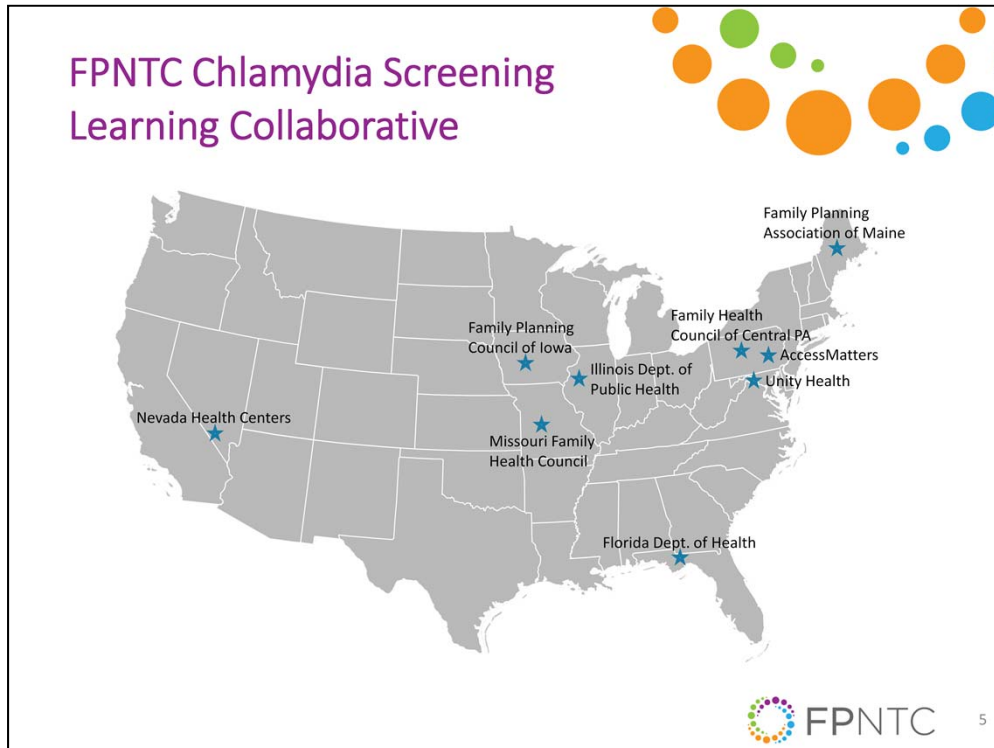
Link: <https://www.fpntc.org/resources/chlamydia-screening-change-package>



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The Chlamydia Screening Change Package was something we developed at the FPNTC. It's a compendium of recommendations for increasing chlamydia screening at Title X sites. This can be used for increasing awareness of best practices strategies, to compare best practice strategies with existing practices in your service site or in your network, and you can use it to find a collection of high impact strategies to implement for quality improvement. There are four evidence based best practice recommendations, and then associated evidence based strategies for implementing those recommendations in the Change Package.

The Change Package really is what guided the FPNTC's Chlamydia Screening Learning Collaborative. And also, we developed after the Learning Collaborative, slide decks and talking points, which we're calling facilitation or discussion guides that are also now posted on FPNTC.org, so that any of you, anyone in the network can use these discussion guides and slide decks as a guide for chlamydia screening quality improvement projects, so those are all available. We encourage you to check them out and to use them in your improvement initiatives.



Using the Chlamydia Screening Change Package as a foundation, as Megan said before, the FPNTC conducted a Learning Collaborative during the summer and fall of last year. We had nine grantee sub-recipient teams from across the country, representing everything from non-profit organizations, FQHCs, and also health departments.

So today, during today's webinar, you're going to hear about some of the things that were learned and also hear from Missouri Family Health Council and Florida Department of Health about their efforts, and successes, and lessons learned around improving chlamydia from their experience in the collaborative.

## Setting a Performance Measure

Measure	Existing Benchmarks	Possible Options for Goal Setting
% of female users 16-24 screened for chlamydia in the prior year	<ul style="list-style-type: none"> <li>Percent sexually active female health plan enrollees screened in U.S. 2015 = <b>49.8%</b></li> <li>Title X 2016 average = <b>61.5%</b></li> </ul>	<ul style="list-style-type: none"> <li>Surpass the Title X average</li> <li>Achieve a percent increase (e.g., 10%) from baseline</li> </ul>

So as with any quality improvement initiative, you want to start with looking at what are you trying to accomplish, where are you trying to go? So each of the Learning Collaborative teams established a goal to increase the percentage of female clients 16 to 24 screened for chlamydia. So, as we'll talk a little bit more in future slides, progress was then measured monthly.

The collaborative participants took a number of factors into consideration when establishing their goals. They were free to select what their numeric goal was going to be, so their chlamydia screening rate, but they were encouraged to set one. Some looked at existing benchmarks such as the percentage of female clients enrolled in health plans that were screened or the Title X average, and others just aimed to increase by a certain percent from their baseline. So they used different methods of setting a goal, but they did all set a goal, and we always encourage that in quality improvement initiatives.

## Performance Measurement

- **HEDIS 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
  - Improvement activities should address screening for all women and men at risk of chlamydia.

Link: <https://www.cdc.gov/std/chlamydia/hedis.htm>



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As you know, chlamydia screening is a HEDIS measure. HEDIS, or the Healthcare Effectiveness Data and Information Set is the tool used by more than 90% of America's health plans to measure performance on important dimensions of care and service. So the HEDIS measure for chlamydia screening is the percentage of women 16 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. This is how it's measured. And, although the HEDIS measure itself focuses on women 16 to 24 years of age, the improvement activities should address evidence based recommendations for screening for all women and men who are at risk of chlamydia and what the recommendations are for screening in those in all of the population.



## Chlamydia Screening Learning Collaborative Results



The percent of female clients 16-24 years of age  
screened for chlamydia

**increased from 41% at baseline to 62%**

by the end of the collaborative.



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The Learning Collaborative was about six months long, as we've said. And across the sites after implementation of the best practices, there was actually an overall increase in chlamydia screening that was pretty significant. The percent of female clients 16 to 24 years of age screened from chlamydia increased from 41% at baseline to 62% by the end of the collaborative. So that's about a 50%, it's actually a little over a 50% increase in screening rates. I think it's fair to say that the participating teams were very successful. And so, the Change Package strategies and recommendations really do work, so we really loved seeing that, and we give kudos to all of the teams that worked hard to implement the strategies.

# Improvement Plan



PLAN					DO	STUDY	ACT
Aim Statement	Tasks	Who	When	Measures			
<i>What do you want to accomplish? By when? (May be the same as or a subset of Step)</i>	<i>What tasks need to be accomplished to reach this Aim?</i>	<i>Who will complete the Tasks?</i>	<i>Task will be done by what date?</i>	<i>How will you know you have been successful?</i>	<i>What progress has been made? What is happening as you make progress?</i>	<i>What do the measures show? What are your observations?</i>	<i>What are your next steps?</i>

Link: <https://www.fpntc.org/resources/chlamydia-screening-improvement-plan>



During the Learning Collaborative, participants utilized a number of tools to work towards their improvement: Each team started with an improvement plan, and they selected one or more best practices to work on, with our recommendation really being that you think about all four of the best practices for maximum impact. They are complimentary. They really are what gives you a full, big picture approach to increasing chlamydia screening rates. And they selected tasks to work on throughout the Learning Collaborative to work towards their goal. Each month participants used plan, do, study, act cycles and updated this tool, and they modified their plans as appropriate for month to month.

# Chlamydia Screening Performance Measure Calculator



**Chlamydia Screening Performance Measure Calculation**

Instructions: This calculator will help you calculate the chlamydia screening performance measure for each site. Enter data from FPAR Table 1 and Table 11 in the rows below. Repeat the process for each site. The performance measure, and your site's comparison to the average performance across all Title X sites, will appear at the bottom of the calculator.

Enter the data below (rows 5-13) from Table 1

Age Group (Years)	Female Users (Table 1, Column A)
Under 15	
15-17	
18-19	
20-24	
25-29	
30-34	
35-39	
40-44	
45 or older	
Total number of female users	0
Total number of female users 15-24 years	0

Enter the data below (rows 18-22) from Table 11

Age Group (Years)	Female Users (Table 11, Column A)
Under 15	
15-17	
18-19	
20-24	
25 or older	
Unduplicated female users tested for chlamydia	0
Unduplicated female users 15-24 years tested for chlamydia	0

Calculated Performance Measure	Site	All Title X**
% of female users 15-24 screened for chlamydia in the prior year**		61.5%

\*Source: Family Planning Annual Report - 2016 Final Report  
 \*\*Note that the HEDIS Measure is 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.

Link: <https://www.fpntc.org/resources/chlamydia-screening-performance-measure-calculator>



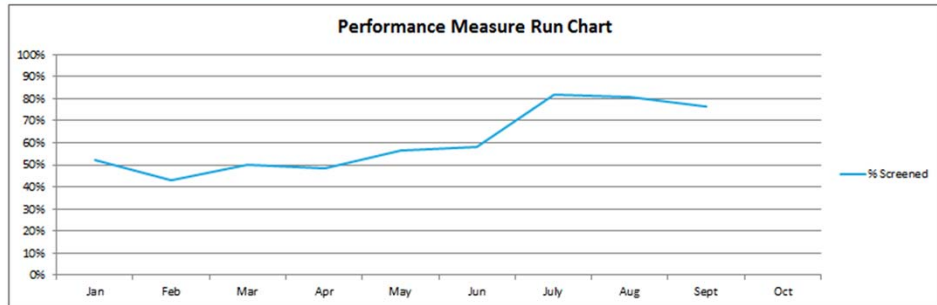
In addition to the actions that they were taking and what they were working on, and we're going to get to what those were comprised of in just a minute. I just wanted to introduce a few tools as we get started. Learning Collaborative participants monitored their progress by using this FPNTC Chlamydia Screening Performance Measure Calculator. And again, as everything else, this is on FPNTC.org. The links for these resources are also on the slide in front of you, and I think we already said at the beginning that you do have access to those slides. This tool, as I said, is on the website, and can assist in calculating rates that are comparable to nationally published HEDIS rates.

To use this tool, you'll need to know the number of female clients served by age group and the number of chlamydia tests performed in these groups. All of that required information can be obtained through the FPAR, the Family Planning Annual Report Data. And that's how you can produce chlamydia screening performance measures and compare it to the Title X average.

# Run Chart



	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Performance Goal
% of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia in the reporting month	52%	43%	50%	49%	57%	58%	82%	81%	76%		55%



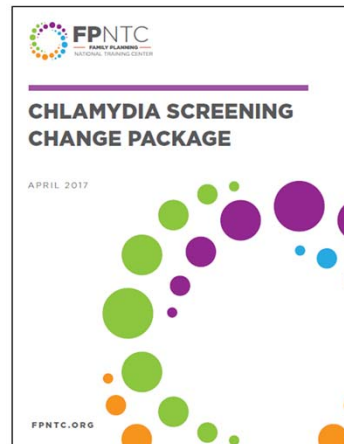
Link: <https://www.fpntc.org/resources/chlamydia-screening-improvement-plan>



Learning Collaborative participants were asked to do this on a monthly basis and then the Chlamydia Screening Improvement Plan, also available on the FPNTC website. We're getting a theme here. The improvement plan has a run chart, that if you enter the chlamydia screening rate, it automatically updates if you enter that monthly data, so you can ... You can also use your own tool, if you have something that does something similar, but you're free to use this tool, if it's helpful, so that you can monitor your performance, and looking at your data monthly is really a great way to track whether or not changes that you're implementing are working the way you think they should be, or the way you want them to be. It's really a great way to monitor over time, and this is all pretty easy to use, or very easy to use, and available on the website.

## Best Practice Recommendations

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**



You'll see in just a minute, we're going to talk about each of these, and we're also going to hear from a couple of the grantees, as we said, and you can see how they were able to use that monthly data tracking and what kind of success they were able to have. But as mentioned earlier, the basis of this whole initiative was the Chlamydia Screening Change Package.

Outlined in this Change Package are four best practice recommendations for increasing chlamydia screening. These really are just a compilation. They've been drawn from a literature review as well as from the QFP, providing Quality Family Planning Services, recommendations of CDC, and the US Office of Population Affairs.

The four best practice recommendations are, just in summary, to first include chlamydia screening as a part of routine clinical preventive care. To use normalizing and opt-out language. To use the least invasive, high-quality recommended laboratory technologies with timely turnaround. And to utilize diverse payment options to reduce cost as a barrier.

And now we want to go into each of these best practice recommendations one at a time.

## 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.

### Strategies

- 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

The first best practice, Best Practice 1, is to include chlamydia screening as part of a routine clinical preventive care for women 24 years and younger, also for women older than 24 who are at increased risk and for men at increased risk, which is what the CDC screening recommendations are.

So because chlamydia screening is recommended for sexually active women 24 years and younger regardless of risk profile, staff can really begin to prepare for the probability of chlamydia screening in this age range even before they arrive at the clinic. Screening can be offered for women in this 24 years and younger with an opt-out approach, meaning that women can refuse screening, if they don't want it, of course, but that the default scenario is that you're really preparing for and anticipating chlamydia screening. Including this opt-out chlamydia screening is recommended for all visits, not just preventive health visits as was traditionally done in the past, so including assessment of the need for chlamydia screening as a part of visits like pregnancy tests, walk in pregnancy test visits, and emergency contraceptives, counseling visits, or problem visits is one of the interventions that has had the very most impact.

And the primary strategies that are recommended for this particular best practice, our first, to have a written policy and protocol for screening all sexually active women 24 years and younger for chlamydia and gonorrhea, and also older women and men who are at increased risk. So really having that written policy and protocol available to everyone and

widely known throughout the agency.

Often having a policy seems to some folks like an afterthought, but we found that it really does increase buy in. It increases the comfort level of staff, and really encourages people to take seriously the quality improvement efforts that you might be working on.

Second, it's recommended that you establish standing orders, if allowed in your institution and in your location, and a standardized workflow. And that you use a team approach to increasing chlamydia screening rate. So it's really important to engage all staff in identifying the clients who should be screened, not just the provider. Often the front desk person, the medical assistant, the patient assistant can look up a chlamydia screening record, can look at whether they fit into the opt-out chlamydia screening age and sex categories, and so can prompt that. It shouldn't just fall on the shoulders of the provider.

Also important to share screening data with staff and providers. This is another thing that it's been very widely found that providers over estimate their chlamydia screening rate. So when asked, they often will say, "Oh, I think my rates ... I asked everybody about chlamydia screening. They must be 90-95%." But when they really tried to look at what their rates really are, it's often lower, and so sharing screening data with staff and providers is a really great way to get them on board and get them focused on this. And then of course do what you can to increase efficiency, so you can easily incorporate this into your services.

## Best Practice 1. Success Story



Pasco County Department of Health,  
*sub-recipient of the Florida State  
Department of Health*

*“Educating clinical staff  
about the high CT rates  
in their area, and  
sharing their success in  
increasing chlamydia  
screening rates by  
screening at all visits...”*



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Okay. So I'm not going to go into this. We're going to hear from Pasco County Department of Health themselves in a few minutes. I'm just going to let you know that they did have a lot of success in changing the way they were asking about chlamydia screening, and so we're going to hear from them in a few minutes.



## 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.

### Strategies

- 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



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All right. The second best practice is to use opt-out language to introduce chlamydia screening to sexually active women 24 years and younger. Again, in this population, their screen's based on sex and age, not on risk. So obviously over 24 and men are based on risk factors, as the recommendations are. But if you use normalizing language to decrease the chance that clients will feel judged, that can really help, using language. Avoid asking questions like, "Do you want to be tested for chlamydia screening today?" Share sample scripts, and have staff practice role playing with opt-out language, and try to encourage them to practice what they might say.

So, "We recommend routine screening, with much the same way immunizations are recommended." Or, "Testing for chlamydia screening is simple. Let's test you while you're here today." Or something like, "We ask everyone if they've been screened at every visit." So really using those kind of normalizing and opt-out approaches.

Include staff ... Again, this is kind of the same, but include all staff in training, not just providers. So all staff with client contact should receive training on preferred and acceptable specimen collection options on current chlamydia screening criteria and national recommendations.

We recommend that they get, everyone have training on the potential sequelae of untreated chlamydia, on chlamydia prevalence, and how to respond to positive results. And

of course, educate clients on the importance of chlamydia screening annually, and how to reduce their risk for STD, again this is using normalizing and opt-out language. So for under 24 using something like, "I recommend a test for chlamydia and gonorrhea to all my clients under 25" is a great way to approach this.

## Best Practice 2. Success Story



Butler County Health Department  
*sub-recipient of the Missouri Family  
Health Council*

*"...trained clinic staff  
on how to introduce the  
CT screening and  
provided opportunities  
for staff to practice..."*

And again, so we happen to have Butler County Health Department and some folks from Missouri to tell us about their successes. They had an incredible increase in their screening rate, but I'm going to let them tell their story in just a few minutes.

### Best Practice 3.

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

### Strategies

- 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

Okay. So Best Practice 3 is using the least invasive, high-quality recommended laboratory technologies available for chlamydia screening, with timely turnaround. This is really the idea of making all optimal urogenital specimen types available, which includes self-collected vaginal swabs for women.

Historically, of course, chlamydia and gonorrhea specimens were collected during pelvic exams at annual preventive health visits at the same time that Pap testing was being conducted. But, as you all know, recommendations for pelvic exams and Pap testing have changed, and fewer pelvic exams are now being conducted. And also around the same time, test technologies now allow for screening without a pelvic exam. So, the 2015 CDC STD treatment guidelines actually cite that chlamydia and gonorrhea, urogenital infections, can be diagnosed in women by testing with either first-catch urine or collecting swab specimens from the endocervix or vagina, and CDC recommends that a self-collected vaginal swab is the recommended sample type.

So, of course if a patient is getting a pelvic exam, they can have a provider collected vaginal swab done. But if they're not having a pelvic exam done, then they can do a self-collected vaginal swab. And vaginal swabs as the recommended sample types, they've been found to be very convenient, they're patient controlled, they're patient collected, which is patient centered. They are efficient. They work into clinic flow nicely. A woman can do the self-collected vaginal swab, even if the patient doesn't have to urinate, which can be helpful.

And they have been found to be highly acceptable for patients, and been successful integrated into clinic flow and into services widely throughout the country.

A few of the suggested strategies to make this successful. Our first, to establish a routine clinic flow processes and systems, just make it clear, and make it routine.

### 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..."*



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The Nevada Health Centers, one of our Learning Collaborative participants, introduced vaginal swabs for chlamydia testing as part of their Learning Collaborative activities. They found that after they adjusted their workflow and worked through their implementation challenges, they said that it worked very well. In fact, one front line staff person said quote, "We used to have women in the waiting room just waiting until they had pee. Now, with vaginal swabs, either the provider does it during the exam, or they can do it themselves no matter what, and they're much happier about that, no more waiting." So, that's one of the many advantages to that approach.

## Best Practice 4.

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

### Strategies

- 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

All right. And the fourth and final best practice is to utilize diverse payment options to reduce cost as a barrier to the client and the facility. We certainly never want patients to turn down recommended screening because of the inability to pay, or because it's an extra cost on top of their visit. But we also understand that service sites have limited resources, so clients should be informed about self-pay and sliding fee schedules, and also about insurance enrollment options.

So the recommendations are to ensure that your organizational policy is inline with Title X program requirements. To ensure client confidentiality, but to bill third parties when possible. To again, provide insurance eligibility screening or application assistance for all clients identified as in need either on site or by referral to any kind of state programs or whatever is available in your location. And then to develop strategies to pay for safety net screening services. So, we know that many states have chlamydia screening support, for example, but not all. But make sure that you are taking advantage of whatever opportunities are available in your state.

## Best Practice 4. Success Story



Iowa Department of Public Health

*“The collaboration with the CDC-funded Community-Based Screening Services program has enabled us to increase our ability to offer screening, reduce costs and expedite treatment...”*



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The Family Planning Council of Iowa partnered with the Iowa Department of Public Health's STD program to provide the state's CDC-funded Community-Based Screening Services program. This program provides testing and treatment for chlamydia and gonorrhea in select sites, including Family Planning sites throughout the state. As a mechanism to pay for safety net screening, the collaboration with the program has enabled them to increase their ability to offer screening. So, it reduced the cost of chlamydia screening to them, and provided screening for those most at risk, which in turn expedited treatment for those who might not otherwise be identified and treated and might have had an untreated infection. They've been really successful with that collaboration.





Grantee Success Stories  
from the Chlamydia  
Screening Learning  
Collaborative



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Okay, so that is a quick overview of the strategies. Now we're going to hear from two teams that participated in the Chlamydia Screening Learning Collaborative. The first that you're going to hear from is the Missouri Family Health Council, who worked with one of their sub-recipients, Butler County. All right, take it away.

## Grantee Success Story

Grantee: Missouri Family Health Council

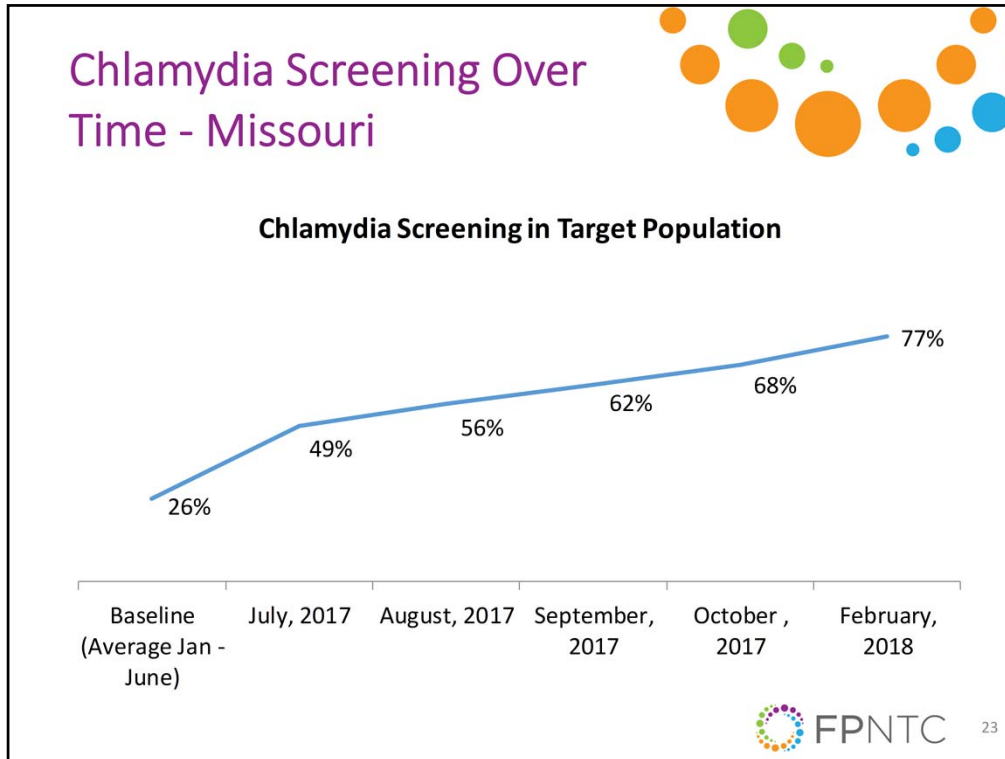
Service Site: Butler County Health Department

**MISSOURI  
FAMILY  
HEALTH  
COUNCIL**



Jayna Gray:

Hi guys. This is Jayna, the director of program at Missouri Family Health Council. We did partner with Butler County Health Department, which is a relatively rural health department in southeast Missouri, and so I'll be going over just some strategies that we did and to look at the numbers.



All right. Whenever we started, in June, our average between January and June was about 26%. You can see that we had a slow. Well, not really a slow. We had a huge increase in July, and so we had a couple of things going on here. One thing that we did as an agency, and as a grantee is we had started doing dashboards, data dashboards with all our sub-recipients, and what that was, was really just looking at the data with the agency.

So, it wasn't just sending out the data to the agencies on our performance measures, which included not only chlamydia screening, but six other performance measures, and analyzing it, looking at it, thinking. When people see their data, they usually think that either it's wrong or we need to just go back and take a further look at that quality improvement, so that actually is what started with Butler County. That was the first thing we did. We looked at what we were doing.

So we analyzed the data, and we looked at the strategies for the biggest increase in a screening. And through this process, we realized that Butler County wasn't using opt-out language when talking to clients about chlamydia screening. Raissa Ameh, which is our clinical manager here at Missouri Family Health Council, was also partnering with myself and Robert at Butler County, and she came out with an opt-out language to use for clients, and developed a pretty little form, and we went over that opt-out language with everybody in the health department that dealt with the Title X clients to make sure that they were using that language, so that was the first thing.

The other thing was, is that everybody at Butler County, I can't say enough about their staff, is that they were willing to change the practice. So it wasn't only like as the grantee we suggested this, and we did the training. They all were willing to adapt to the change, and were excited about seeing the numbers increase over this collaborative. They did a great job with that.

Also, we looked at some policies that they had, and changed some policies, and just some language that they were using on some consent forms, and such things as that.

## Most Impactful Changes - Missouri

- Changing language to “opt out” language for Chlamydia screening
- Analyzing and reviewing agency data
- Be willing to change and practice

The next steps and opportunities that we had for Missouri is we presented the opt-out language for chlamydia screening to our network. So we have a monthly ... I'm sorry, a quarterly meeting where everybody, one representative from each of our sub-recipients, the 18, come to Missouri, so we're all in the same place. What we did was, we reviewed what we had done with Butler County over the summer, because our meeting was in August, and so Raissa presented that opt-out language flier form that staff could put in their exam rooms and went over using the opt-out language, doing some role playing, and so we took that in August, just the opt-out part of it, network wide.

The next thing that we did was, we knew that there was some differences in the CDC requirements for screening and what the state funded STI program would pay for. Raissa and I went to an STI training that was done by the Missouri Department of Health and Senior Services and got familiar with what their recommendations were based on the funding that the state could afford. They had a big cut in their STI program, and so they had backed out of some of the CDC requirements, concentrating more on high risk and that one test per year.

So we went through the training, and then also from that we really established a partnership with the STI bureau. We have quarterly meetings with them to hear what they're doing and they're seeing in the field, and we share what we've been doing and seeing in the field, and really building that collaboration between the two of us. That's

really helped the sub-recipients. That only was chlamydia screening, but other STI screenings.

## Next Steps, Opportunities and Challenges - Missouri

- Network change
- CDC screening recommendations & state-funded STI programs requirements

The next thing is that we changed ... The most impact we had was the opt-out language, and so we changed the opt-out language for the network wide, so that was the biggest outcome that we've had by doing this. And if you remember for the first slide, we started out like 26%, and we're at 77% at the end of this collaborative. So, by changing the opt-out language, training the staff, and also continuing on analyzing that data, we have made a huge impact in the screening that has been done throughout the state.

We still have some agencies that are trying to adapt the opt-out language, and the biggest thing that we find is not that they're not willing to do it; it's really figuring out the STI program, and what they'll pay for screening, and then, like you guys had said with your best practices, is finding that other funding piece. And so, we've worked together with them. We've been really impressed with Butler County and what they've been able to do, and it's a lot easier when you're sharing with sub-recipients, when one agency is successful and they kind of meet that bar, and then other agencies want to also tap into that.

So, that's really what I have for Missouri, and I want to again thank Butler County and Raissa Ameh, the clinical manager. She's a women's health nurse practitioner that is on my team, our team, and we've done some great work, and we'll continue on doing it. Thank you.

## Grantee Success Story

Grantee: Florida  
Department of Health



Service Site: Pasco County  
Health Department



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Jennifer Kawatu:

Great. Thank you so much. That really is incredibly impressive. You tripled your screening rate, and it's also so great to hear about the collaboration between family planning and STDs. You're working at the agency, the county, and the state level, so all of that coordination and collaboration is really paying off, and we're just so pleased to be able to share your incredible success story, so thanks for sharing that.

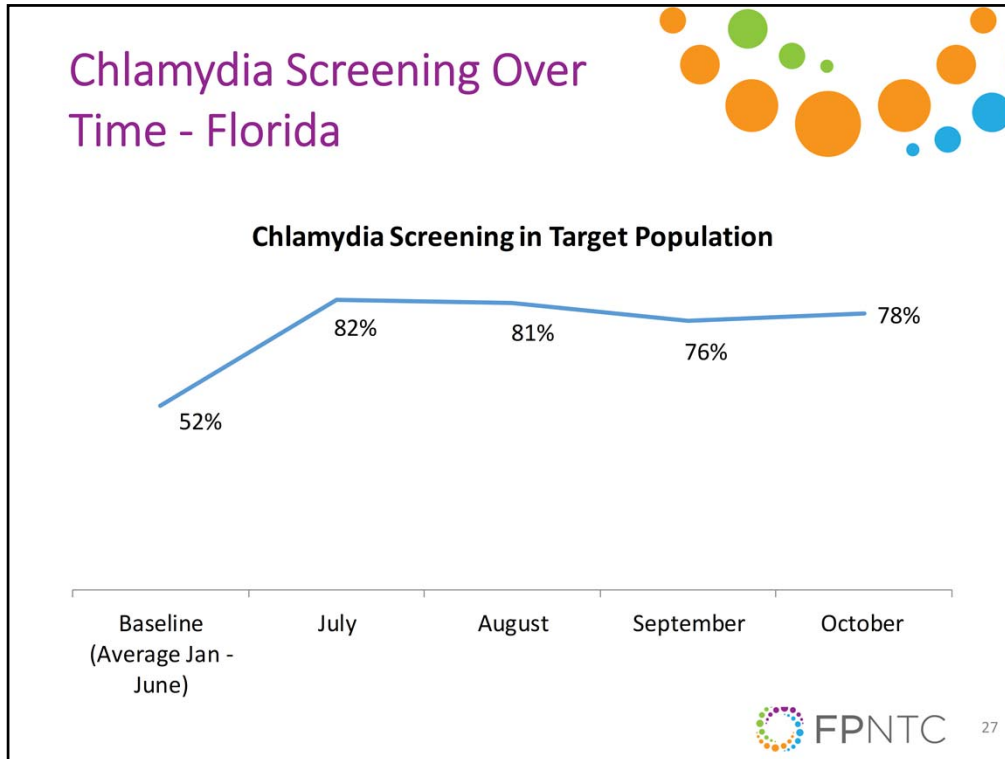
All right. And next we're going to hear another really great story from Florida, from Pasco County Health department.

Tonia Walden:

Hi. My name is Tonia Walden. I work for the Florida Department of Health. [Latheria Charleston 00:37:53] is the guarantee at the state office level. I myself work at the Pasco location, the service side, and that's where we actually did the Learning Collaborative to see what kind of improvements we could make.



## Chlamydia Screening Over Time - Florida



If you can see our ... When we first started, our baseline was around 52%. Here at Pasco DOH, we had always already included chlamydia screening in our routine exams like our annual exams and our initials, those kind of things. We had all of the different types. We had urine, we have vaginal swabs available, and we do offer diverse payment options, so our biggest area for improvement was trying to figure out where we could make the biggest impact to improve our screening rates.

## Most Impactful Changes - Florida

- Including nurse visits in the screening process was the most impactful
- Three of four of the best practices used were already happening to some degree at FL DOH.
- Discuss collaborative with staff to help understand why change was important.
- Implemented as part of regular routine for nurse visits just as with other FP visits.

So we got together with the staff, and we discussed it, and we talked about ... There were higher rates of chlamydia in Pasco County, and we discussed how we could make this a successful endeavor, and how we could improve our screening rate. So together with the staff, once we talked about how to do it, we came up with a plan to include chlamydia screening with our contraceptive refill location.

So, if people came in just wanting birth control, they were up to date on their annual, or they were going to come back and get the annual at a later date for one reason or another, we actually started screening those women. When they came in for birth control, they always had to leave their urine, so we would just at the same time say, "I need you to leave a urine sample," and then we would explain self-collection of the vaginal swab.

The ones that we had found that didn't feel comfortable doing that, we were actually able to collect that during the exam. So, if they didn't have an exam, we actually allowed the nurses to take them in a room, and collect it for them. But most of the time, everyone was very, very comfortable once we explained it and just said, "It was part of the routine visit," doing that.

So we did include on all the nurse visits, and it has been very successful. We were able to increase our rate by almost 30% in the six months that we did the collaborative. We are working on updating our policy, so that we can incorporate this into a policy that we are going to be discussing, possibly implementing. But we have continued to include the screenings with the visit. And I don't have the exact number for today, but I know that our

chlamydia screening rates are still well above what our baseline was.

## Next Steps, Opportunities, and Challenges - Florida

- Continue to remind staff of importance of chlamydia screening in FP clients
- Continue to include as normal part of any type of FP visit
- Challenges could be clients declining screening

Everyone here at DOH was very excited about the possibility to be involved with something to help make our community safer and more healthy, so it was very easy as we ... We also as each month when I got an update on how we were doing, I would make sure I met with the staff, so that all of us could understand that we were really making a difference. It seemed every month the higher that our screening rates got, the more determined the staff was to do better because they were really excited to actually see this change happening first hand essentially month to month with the screening rate, so they worked really hard.

The next steps in opportunities and challenges. We will continue to remind the staff of the importance of chlamydia screening. We also do a lot of education with our clients, so if there's ever anyone that doesn't want it, we'd say, "Okay, that's fine." But we do take a moment to educate them on why it's important.

We will continue to include it as part of our normal visit. I think the biggest challenge that we have currently is just if the clients decline the screening. But we have found that the ones that have, once we gave them that little education, explained to them why it was important, and how it was safe, and it made them overall healthier, and they were always aware of their medical conditions, then we've had very few people that actually flat-out say "no" the whole time that we've been doing this, and we started it in July. It's been very rewarding, and it's been very good to watch the staff, and our clients actually seem to be pleased and benefit from this practice.

We will continue to include it in part of all of our visits, and just keep monitoring to make sure that it includes ... We're also going to be looking at other ways such as ... What I mean by that is making sure that the appropriate site is screened. It's not just vaginal screenings that chlamydia can be in. It's also anal and oral, and so right now we're currently discussing how to get that into practice, so that we can get better at making sure we screen any area that might possibly have been infected or in contact with the chlamydia virus.

Jennifer Kawatu:

All right, great. Thank you so much.

That is such a great example of using data to drive your quality improvement initiative. As you said, I loved how you said that the more you shared with them and the more you shared that they were increasing, it drove their desire to do better, and to keep doing better, and to keep improving, so that's really how quality improvements work, and it's just such a great illustration of that. Thank you so much for sharing that.

## The Quality Improvement (QI) Team

- A QI team should include representation from:
  - Clinical
  - Administration/clinic management
  - Billing and coding
  - Front desk
  - Clinical assistants
  - Finance
- Who is involved already, and who do you need to add?

We just want to kind of wrap up with just a few thoughts about recommendations for how you can put this into place. We hope you're feeling excited about the possibility of improvements that you can make at site, but knowing that quality improvement is a team effort, so we hope you will, if you're starting a quality improvement initiative, a chlamydia screening improvement initiative, that you create a team that represents all of the systems to work on this.

## Next Steps

- Designate regular meeting time for QI team
- Involve more staff on the QI team, if needed
- Identify when future sessions will take place and who needs to be there
- Designate staff member to collect and report data on a regular basis (e.g., monthly)
- Designate meeting time to *develop a site-level improvement plan*

And it's always a good idea to designate regular meeting times. Designate who is going to provide the data, how often. Monthly is a good period of time to look at your data. And designate regular meeting time. And develop an actual improvement plan to drive your improvement efforts.

We can see that when it's done like that, as the Learning Collaborative participants shared, it can be really, really successful. You can see that they were very, very successful in their efforts.

## Resources available on fpntc.org

- [Chlamydia Screening Change Package \(updated April 2018\)](#)
- [Increase Chlamydia Screening in Family Planning Settings Discussion Guide & Slides](#)
- [Chlamydia Screening Performance Measure Calculator](#)
- [Chlamydia Screening Improvement Plan](#)

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	
<b>How to Use This Guide</b>	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 <a href="#">Chlamydia screening performance measure</a> . Facilitators should feel free to adapt and revise this guide. Facilitators may choose to: <ul style="list-style-type: none"><li>• 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.)</li><li>• Convene a one-time meeting with clinic staff about this topic.</li></ul>
<b>Learning Objectives</b>	By the end of the discussion, participants should be able to: <ul style="list-style-type: none"><li>• Explain the benefits of using an opt-out approach to chlamydia screening for sexually active women 24 years and younger</li><li>• Describe at least two examples of opt-out and normalizing language to promote chlamydia screening.</li><li>• Identify at least two strategies to increase staff comfort in normalizing language related to chlamydia screening</li></ul>
<b>Length</b>	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.
<b>Materials</b>	<ul style="list-style-type: none"><li>• <a href="#">Chlamydia Screening Change Package</a>: Summary of evidence-based recommendations for increasing chlamydia screening rates, strategies, case studies, tools, and resources</li><li>• <a href="#">PowerPoint Slides with Notes</a>: Slides with speaker notes and discussion questions</li></ul>
<b>Format</b>	Discussions can be facilitated <b>virtually or in person</b> .
<b>Suggested Participants</b>	Staff from <b>one or more family planning clinics</b> . Involving multiple sites can facilitate peer-to-peer sharing. Having representation of clinical, administrative, and financial staff can help address system issues.
<b>Before You Start...</b>	Participants should <b>calculate site-level performance</b> on the Chlamydia screening performance measure using the Chlamydia Screening Performance Measure Calculator if needed.

All right. Just a little bit of a reminder that there are resources available on FPNTC. There are actually quite a few resources. We've shared some of them, but there are also a few more things that are on there that we haven't specifically mentioned. But there are now these discussion guides. This is just a screenshot of one of our discussion guides for one of the sessions. But there is the Screening Change Package, then there are discussion guides for each, for an introduction and for each of these best practices.

There is the Chlamydia Screening Performance Measure Calculator, and then the Improvement Plan, which also has that run chart where you can track that nice ... That's actually what the screenshots were from, from the grantees that talked, was seeing their data on a monthly basis, so you can make your own just by plugging in your data.

Again, now that we have these PowerPoint slides and the accompanying discussion guides related to each of the best practices, you can just take those and use them to conduct network wide learning collaboratives of your own, if you want, or just use them with your site. You can take them. You can just use small pieces of them or full slides that are useful to you. Feel free to use those in whatever way is helpful to you, in the way that you want to, to address specific areas of need of improvement.

We hope that these are helpful. These are new resources up on the website, and so we look forward to hearing any feedback or suggestions that you have about them. Let us know what you think.





I think we should have time for a few questions. I've seen a couple of questions come in, in the chat box already, and we should have enough time. If anyone else has questions, please feel free to put them in the chat box, and we'll get to as many of them as we can.

Megan Hiltner:

All right, thanks Jennifer.

The first question is actually for you, and it's in reference to best practice number three: Use the best, least invasive high-quality recommended laboratory technologies available for chlamydia screening with timely turnaround. Just wanted to refresh everybody's memory.

So the question is, "What about swabbing the pharynx or rectum?"

Jennifer Kawatu:

Okay. Yeah, that's a great question, and it's not one with a super easy answer, or one that we'll be able to get into the details about. But basically, you can do pharynx or rectal

screening, if you're using a NAAP, a Nucleic Acid Amplification Test, or if you have the ability to do cultures, you certainly can screen them. There are not widespread recommendations to screen women in either the pharynx or rectum, if you are already screening them vaginally.

So, if you're already doing a vaginal swab, studies have shown that you don't actually catch very many more infections, unless on sexual history they've told you that they don't engage ... If for some reason ... I mean there are certainly ... You should be going a comprehensive sexual history, and if what they tell you is different, then you should obviously screen differently. But, in terms of just doing widespread screening, in terms of just regular protocol, there are not currently recommendations for screening all sites.

Among men however, and especially MSM, men who have sex with men, the recommendations are somewhat different, and there is a recommendation to, again, screen based on the sexual history, but that there are different recommendations. And again, I don't think I talked about screening samples for screening men, but the recommended screening for men is to use the urine sample. However, if upon sexual history you find that other, either pharynx or rectal screening is recommended, then that would be separate.

I hope that answers your question. I know it's not a super simple answer, but obviously each patient is different, and you'll have to treat them, but currently there are not widespread recommendations for female patients.

Megan Hiltner:

Thank you, Jennifer.

We've got a couple of questions in the chat box based on the great resources and information shared from the two grantees that shared their stories about their willingness to share policies, opt-out language forms, sample scripts, that sort of thing. We will work with the folks on the line to see what they would be willing to share, and what we can post. I just wanted to address those two folks that asked those two questions about sharing that.

Megan Hiltner: Go ahead, Jennifer.

Jennifer Kawatu: Megan, can I just throw out?

Megan Hiltner: Yeah.

Jennifer Kawatu:

I just wanted to recommend. There is actually, in the Chlamydia Screening Change Package, there is a whole ... Let's see. It's on page nine ... several options of sample language to use for opt-out. Yeah, for opt-out questioning about screening. So there are recommendations, but we'll see what else we can recommend as well, but I just wanted to point people in that direction, if that's helpful. That's already available and posted to the website.

Megan Hiltner:

And the page number even. Great.

The next question is for our two presenters, for you, Jayna, or Tonia, or Latheria too. But with the increase in screening that you saw, was there an increase in positivity rates? And what are the treatment rates? This person's just curious. Can you share?

Tonia Walden:

I think there was a slight increase in positives. This is Tonia from Florida. I think it's just because we caught some of the ones that we hadn't previously screened. I don't know what that actual rate is. I'm sorry. I don't have ... I haven't ever sought out that specific number. I was more focused on the overall screening, but I don't actually know what our positive rate is here in Florida. I'd have to look into that.

Jayna Gray:

This is Jayna from Missouri. I'd have to say the same thing. We actually don't collect the results of the screening. I know the STI bureau does, and as a state, we've been up more. We've actually had a huge increase for chlamydia screening, but we have had an increase in the positive. I do think that, that is a collaboration, probably because of the local health departments are doing more, the ones that are in our network. But I couldn't tell you for that for sure, and I couldn't tell you the numbers.

Megan Hiltner:

Great. Well, thanks for sharing.

Another question here, and this is specifically for you, Tonia in Florida.

In Montana, reimbursement for new clients during nurse visits is not covered. Did you come across this issue, and how did you work with your clinics to resolve?

Tonia Walden:

I haven't really had an issue with that because when the client comes in, and speaks with the RN, and gets the screening, and all that, she's doing contraceptive counseling on her, so it's covered under contraceptive counseling. They're able to be paid that way because that's essentially ... When they come in for a birth control refill, that's what they're doing, and so we just kind of [inaudible 00:53:29] part of the contraceptive counseling to get them on some birth control. Does that help?

Jennifer Kawatu:

I just have a question. So she's talking specifically about nurse visits. When you're talking about the contraceptive counseling, and getting them on birth control, is that a nurse practitioner, or an advance practice nurse, or an RN?

Tonia Walden:

Here in Florida, RNs are allowed to work under standing protocols by the MD through the health department. It's not all of Florida, but through the health department.

Jennifer Kawatu: Okay. Well, that's a Florida ...

Tonia Walden: Correct, so I don't know about other states. I know in Florida, the Department of Health are allowed to do that. I don't know about other states.

Jennifer Kawatu: Okay.

Yeah just for Montana ... So that was really helpful though. Thank you. For Montana, you're correct. That reimbursement for new clients can't be billed as just a nurse visit. It would normally have to be, if it's going to be billed as an evaluation and management visit, it would have to be either an established client or seeing a provider, a nurse practitioner, or a PA, or

an MD.

But someone else here is saying that in California, there are RN who does birth control visits, so I think there is a lot of ... Well, we know that there's a lot of state to state variability here, and that reimbursements, there's just some state to state variations.

Megan Hiltner:

Another followup question regarding billing. In issues regarding insurance reimbursement, they're finding that they often won't pay, as the patient may have received her annual screening with her PCP, and will receive a bill for insurance from an insurance company. If they do a screen, this causes their screening rates to be lower than they'd like. Any recommendations in that space?

Jennifer Kawatu:

Yeah. I'm going to start, but then if Florida or Missouri has anything to add, I'd love to hear what they have to say. And I'm also going to refer, there's another question I hear that, "How is screening every single supply visit cost effective for the clinic, or for the individual, or for the healthcare system for that matter?" I think those are related and are great questions actually.

The recommendation is not that you would screen every single supply visit, or that you would screen every patient who comes in every time. That is ... I'm sorry if that was the impression I gave. That is not the recommendation. The recommendation is that you assess at every visit whether they should have screening.

So assessing, some patients never come in for a preventative health visit, so you would assess and find out that they have not been screened by their PCP, or they don't come for preventative health visits, and so catching them at a walk-in might be the only time that they get screened or have the opportunity to get screened.

However, if they tell you that they've been screened by their PCP, or if they were screened at your location recently, then the recommendation from CDC is to screen at least annually, and only additionally if there are reasons, if there are risks for which you're screening. But the just actual screening should be done annually, or more if needed. So again, the recommendation is just that you look at the record. You question it. And you think about screening. Make an assessment every time they're there in front of you whether they need it. It doesn't mean that you would screen them every time.

Anything to add?

Tonia Walden:

No. This is Tonia.

I completely agree with that, and that's the way that we ... Because you don't know. There are a lot of people, especially here, that don't always go to their primary care and things like that, so that was our goal, was to increase with the birth control, so that we could catch those that aren't really doing the things they're supposed to be doing, and not following as closely as they should be.

Jayna Gray:

This is Missouri. We don't have Medicaid expansion in our state, and so we still serve a large ... Over half of our clients are uninsured, and so I would say what Tonia said too. We're trying to catch those clients that may not go to a primary care too.

I think that was a barrier. Agencies thought that we might like to screen all the time. And it's how you explain it, and teach it too, and reiterating that is huge.

Tonia Walden: Great.

Megan Hiltner: Great.

Well, with that, I just wanted to thank everybody for joining today. As I said in the intro, we hope to have the recording and the transcript of the session available within the next few days.

And as a reminder, the best practices that we covered today are addressed in the Chlamydia Screening Change Package on the FPNTC.org website, along with other training tools that were highlighted.

Finally, please complete the evaluation today. It will pop up on your screen when you exit this session. We would really love your feedback, and we'd love to use it to inform our upcoming webinars as well.

Thanks to all of our speakers today, and thanks to all of you for joining us today. This concludes the webinar.



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Thank you!

Contact:

[fpntc@jsi.com](mailto:fpntc@jsi.com)



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