CHLAMYDIA PREVENTION: CHALLENGES AND STRATEGIES FOR REDUCING DISEASE BURDEN

- Sami L. Gottlieb, MD, MSPH
  - Chlamydia: Magnitude of the Problem and Opportunities for Prevention
- Catherine L. Satterwhite, MSPH, MPH
  - Chlamydia Prevention Challenges and Strategies to Address Them
- Raul A. Romaguera, DMD, MPH
  - Addressing Health System Issues, Societal and Individual Challenges
- Gail Bolan, MD
  - Chlamydia Prevention at the State Level: The California Experience
- Gale R. Burstein, MD, MPH
  - CDC Partners Address Chlamydia Prevention
Sami L. Gottlieb, MD, MSPH

Medical Epidemiologist

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

NCHHSTP
Clinical features of chlamydia and risk for adverse reproductive outcomes
National burden and associated costs
Chlamydia prevention interventions
Chlamydia: Clinical Manifestations

- **Chlamydia**: Sexually transmitted infection caused by the bacterium *Chlamydia trachomatis*
- Vast majority asymptomatic
- **Lower genital tract infection**
  - Cervicitis – discharge, cervical friability
  - Urethritis – dysuria, discharge
- **Can ascend to the upper genital tract**
  - Men – epididymitis
  - Women – pelvic inflammatory disease (PID)
Pelvic Inflammatory Disease (PID)

- Infection/inflammation of uterus, fallopian tubes, ovaries
- Clinical diagnosis imprecise: Lower abdominal pain AND uterine OR adnexal OR cervical motion tenderness
- Multiple etiologies
  - *Chlamydia trachomatis*
  - *Neisseria gonorrhoeae*
  - Bacterial vaginosis
- Symptoms can be mild; subclinical tubal infection and inflammation occur
Long-term Reproductive Complications

- Tubal inflammation can result in scarring, loss of function
- Long-term sequelae
  - Tubal factor infertility
  - Ectopic pregnancy
  - Chronic pelvic pain
- Tubal factor infertility: Inability to conceive due to fallopian tube damage

Chlamydia is the leading preventable cause of tubal factor infertility

Scanning electron microscopy photos courtesy of Dorothy L. Patton, University of Washington, Seattle, WA
Risk for Sequelae in Women

- Untreated chlamydial infections
  - 10-15% risk of Clinical PID
  - 10-15% risk of Tubal factor infertility

- Clinical PID
  - 10-15% risk of Tubal factor infertility

- Tubal factor infertility
  - ? Risk of Subclinical tubal inflammation

- Subclinical tubal inflammation
  - ? Risk

References:
Oakeshott et al, BMJ 2010
Weström et al, Sex Transm Dis 1992
Land et al, Hum Reprod Update 2010
Diagnosis and Treatment

- **Diagnosis**
  - Nucleic acid amplification tests (NAATs)
    - Sensitivity ~96%, specificity >98%
    - Specimens: Urine; vaginal, cervical, and urethral swabs

- **Treatment**
  - Simple and efficacious: Single-dose oral azithromycin
Clinical features of chlamydia and risk for adverse reproductive outcomes

National burden and associated costs

Chlamydia prevention interventions
Burden of Chlamydial Infection

- Most commonly reported nationally-notifiable disease
  - Over 1.2 million cases reported in 2008
  - Many infections not detected
- Estimated 2.8 million cases occur each year
- Direct medical costs: $678 million/year

Weinstock H, Berman S, Cates W Jr. Perspect Sex Reprod Health 2004
Chesson HW, et al. Perspect Sex Reprod Health 2004
Burden of Infection Highest Among Sexually Active Adolescents and Young Adults

Sexually active people aged 14-24 have about 3x the chlamydia prevalence of sexually active adults aged 25-39

NHANES, National Health and Nutrition Examination Survey, 1999-2008
Sexual activity = “yes” response to “Have you ever had sex?”
Sex = vaginal, anal, or oral sex
Large Racial Disparities In Chlamydial Infection

NHANES, National Health and Nutrition Examination Survey, 1999-2008
Analysis of sexually active 14-39 year-olds; Sexual activity = “yes” response to “Have you ever had sex?”
Sex = vaginal, anal, or oral sex
Chlamydia Prevalence in Sexually Active Females Aged 14-24 in the United States

**Chlamydia Prevalence in Sexually Active Females Aged 14-24 in the United States**

NHANES, National Health and Nutrition Examination Survey, 1999-2008

Sexual activity = “yes” response to “Have you ever had sex?”

Sex = vaginal, anal, or oral sex
Over 750,000 cases of PID occur each year

Burden of chlamydia-related PID difficult to determine

- Diagnosis subjective, non-specific
- Multiple causes
- Proportion associated with chlamydia may vary
  - Older studies: ~1/3 of PID cases
  - May be higher now due to lower gonorrhea prevalence

Sutton et al, Sex Transm Dis 2005
In 2002, 7.4% of married women aged 15-44 were infertile (failure to conceive ≥12 months)
- Almost 1 in 5 women aged 40-44 reported they had received a medical service for infertility

Proportion of infertility that is tubal factor varies by clinical setting
- Ranging from 10%-40%
- Higher among blacks

Costs of infertility exceed $5 billion/year
Clinical features of chlamydia and risk for adverse reproductive outcomes
National burden and associated costs
Chlamydia prevention interventions
Rationale for Chlamydia Prevention Programs

- High burden of chlamydia in young women
- Chlamydia is a major preventable cause of PID, infertility, and other adverse outcomes
  - Associated with substantial costs
- Chlamydia is easily diagnosed and treated
Chlamydia Prevention Programs

- **Main goal: Reduce reproductive sequelae**
  - Treating infected women before infection progresses (secondary prevention)
  - Reducing transmission in the population (primary prevention)

- **Main intervention: Screening women for asymptomatic chlamydial infection**
Screening Women for Chlamydia: Current Recommendations

- Recommendations by CDC, United States Preventive Services Task Force (USPSTF), medical associations
  - Screen all sexually-active females aged <25 years annually
  - Screen women aged ≥25 years if at increased risk

- USPSTF: A-rated recommended preventive service

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<th>Non-Pregnant Women</th>
<th>Pregnant Women</th>
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<td>24 yrs &amp; younger</td>
<td>25 yrs &amp; older</td>
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<tr>
<td>Includes adolescents</td>
<td>Not at increased risk</td>
<td>At increased risk</td>
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<td>Recommendation</td>
<td>Screen if Sexually Active</td>
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<td></td>
<td>24 yrs &amp; younger</td>
<td>25 yrs &amp; older</td>
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<tr>
<td>Includes adolescents</td>
<td>Not at increased risk</td>
<td>At increased risk</td>
</tr>
<tr>
<td></td>
<td>A</td>
<td>Screen</td>
</tr>
</tbody>
</table>

http://www.ahrq.gov/clinic/uspstf/uspschlm.htm
Screening Women for Chlamydia: Evidence

- Three randomized controlled trials: Chlamydia screening can reduce incidence of PID
  - Seattle HMO: Women with one-time screening had >50% reduction in PID at 1 year (RR 0.44, 95% CI 0.2-0.9)

- Secondary prevention benefit to infected women
  - In addition to potential role in primary prevention through reducing burden in population

Scholes et al, NEJM 1996
Østergaard et al, Clin Infect Dis 2000
Oakeshott et al, BMJ 2010

RR, Relative risk
CI, Confidence interval
Chlamydia Prevention Programs

- **Main goal:** Reduce reproductive sequelae
  - Treating infected women before infection progresses (secondary prevention)
  - Reducing transmission in the population (primary prevention)

- **Main intervention:** Screening women for asymptomatic chlamydial infection

- **Other prevention interventions**
  - Behavioral risk-reduction efforts
  - Finding and treating male sex partners
  - Screening women for repeat infection
Expedited Partner Therapy (EPT)

- CDC and medical associations endorse expedited partner therapy (EPT)
- EPT: Providing prescriptions or medications to the patient to take to her partner
  - Without examining partner first
- Two RCTs: EPT useful in assuring partner treatment and reducing repeat infections

Schillinger et al, Sex Transm Dis 2005
Golden et al, NEJM 2005

Photo courtesy of Dr. Cornelis A. Rietmeijer, Denver Public Health Department
Re-screening After a Chlamydial Infection

- **Recommendations from CDC**
  - Re-screen 3 months after initial infection

- **Rationale**
  - Repeat infection common: Peak reinfection rate 20% at 1 year
  - Repeat infections may be more harmful

Hosenfeld et al, Sex Transm Dis 2009
Opportunities for Prevention

- Large burden of chlamydia in the United States
- Major preventable cause of PID and infertility
- Evidence-based prevention interventions available
CHLAMYDIA PREVENTION CHALLENGES AND STRATEGIES TO ADDRESS THEM

Catherine L. Satterwhite, MSPH, MPH
Epidemiologist
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
NCHHSTP
Screening Women for Chlamydia: Current Recommendations

- Chlamydia screening recommended for sexually active females under 25 as an A-rated preventive service
- Ranked by National Commission on Prevention Priorities
  - 1 of the 10 most beneficial and cost-effective USPSTF-recommended preventive services
  - Among most under-utilized (<50% women screened)

Priorities Among Effective Clinical Preventive Services
Results of a Systematic Review and Analysis
Michael V. Maciosek, PhD, Ashley B. Coffield, MPA, Nichol M. Edwards, MS, Thomas J. Flottemesch, PhD, Michael J. Goodman, PhD, Leif I. Solberg, MD

USPSTF, U.S. Preventative Services Task Force
History of Chlamydia Screening: The Infertility Prevention Project (IPP)

- Pilot in 1988: Detect and treat chlamydia and gonorrhea infections among young women to prevent infertility
- Screening recommendations in 1993
- Nationally implemented by 1995
  - Congressionally mandated
  - Publicly-funded family planning clinics
  - >3.5 million test results reported annually
CHLAMYDIA PREVENTION CHALLENGES AND STRATEGIES TO ADDRESS THEM

- **How successful are programs?**
  - Evaluate impact: Trends in chlamydia burden and adverse outcomes
  - Evaluate implementation: Chlamydia screening coverage

- **Next steps: Areas for program improvement**
Assessing Chlamydia Trends: Which Data Should Be Used?

- Case report data currently problematic for trends
- Reported chlamydia cases expected to increase as more cases are detected
  - Positive measure of program impact

Must rely on other data sources to assess national chlamydia trends
Other Sources for Chlamydia Prevalence Data


![Graph showing Chlamydia Prevalence by Sex and 2-Year Interval, 1999-2006](image)


*Ages 14-39 years
**National Job Training Program**
- High-risk women and men, aged 16-24 years
- Screened for chlamydia at program entrance
- Prevalence decreased, 2003-2007
  - Women: 19% decrease
  - Men: 8% decrease

**Infertility Prevention Project (IPP)**
- Women tested in family planning clinics, aged 15-24 years
- No change in positivity rates, 2003-2007

Chlamydia prevalence stable or decreasing, NOT increasing

NJTP Source: Satterwhite et al. Sex Transm Dis 2010;37(2):63-37
IPP Source: Satterwhite et al, unpublished data
Assessing Adverse Outcomes: Do We Have the Appropriate Data?

- **PID**
  - No national trend data on chlamydia-associated PID
  - PID diagnosis subjective, insensitive, non-specific

- **Infertility**
  - No data on chlamydia-associated infertility
  - Limited trend data on overall infertility

- **Ecologic comparisons**
  - PID and infertility have multiple causes

No chlamydia-specific data available to monitor adverse outcomes
Strategies to Improve Measurement of Trends in Chlamydia Burden and Adverse Outcomes
Strategies to Improve Measurement of Trends in Chlamydia Burden and Adverse Outcomes

- Monitoring pregnant women to minimize impact of health care seeking behaviors
- Engaging with CMS to pilot implementation of Medicaid Sentinel System
- Collaborating with non-traditional partners (e.g., HMOs) to develop improved methodologies to measure trends
- Developing national action plan for prevention, detection, and management of infertility
  - Emphasis on improving infertility surveillance
How Successful Are Chlamydia Prevention Programs in Reducing Disease Burden?

- Chlamydia prevalence stable or decreasing
- Data suggest decreases in PID
- Are high-risk populations being impacted?
  - Chlamydia prevalence extremely high in young, black women

Current chlamydia prevention programs are having some impact, but not enough
How successful are programs?
- Evaluating impact: Trends in chlamydia burden and adverse outcomes
- Evaluating implementation: Chlamydia screening coverage

Next steps: Areas for program improvement
Program Implementation: Chlamydia Screening Coverage

- **Healthcare Effectiveness Data and Information Set (HEDIS)**
  - Performance measurements to assess quality of care in managed care organizations (MCOs)
  - 90% of MCOs report on HEDIS measures
  - Chlamydia screening measure implemented in 2000
    - Proportion of eligible women tested within calendar year

Chlamydia Screening Coverage

Percentage of Enrolled, Eligible Women Aged 16-24* Years Screened for Chlamydia, by Health Plan Type, HEDIS, 2000-2008

MMWR, April 17, 2009/58(14);362-365
Chlamydia Screening Coverage: Measurement Challenges

- **Coverage among health care seeking population**
  - Population-based screening coverage
  - Addressing the challenge: develop approaches to estimate community levels of screening coverage
    - Critical for future intervention strategy research
    - Use existing data sources: reproducibility

- **Frequency of screening**
  - Annual screening recommended
  - Data suggest very few women screened annually

- **Defining denominator: Determination of sexual activity**
How Successful Are Chlamydia Prevention Programs in Implementing Interventions?

- Screening coverage among health care seeking population is low, but improving
- No national data available to evaluate other interventions
  - Partner treatment
  - Rescreening
CHLAMYDIA PREVENTION CHALLENGES AND STRATEGIES TO ADDRESS THEM

- **How successful are programs?**
  - Evaluating impact: Trends in chlamydia burden and adverse outcomes
  - Evaluating implementation: Chlamydia screening coverage

- **Next steps: Areas for program improvement**
What is the Best Strategy for Reducing Disease Burden?

- **Increasing screening coverage?**
  - Broadly
  - Targeted screening (e.g., venue-based)
- **Increase use of other interventions?**
- **Combined approach?**
  - How to allocate resources?
What About Men?

- **Limited resources**
- **Screening men**
  - No substantial secondary prevention
  - Men difficult to reach due to limited health care seeking
- **Highest risk: Partners of chlamydia-infected females**
Determining the Best Strategy for Chlamydia Prevention

- **Mathematical modeling**
  - Combination of intervention strategies may be most effective
  - Increase routine screening of young, sexually-active women and increase partner notification and treatment efforts
  - Male screening: Limited impact on prevalence among women

- **Partner treatment interrupts transmission**
  - Reduction in repeat infections

**Partner treatment is an essential component of chlamydia prevention**
Chlamydia Prevention Programs: Next Steps

- Expansion of intervention strategies
- Improving measurement of impact and implementation
- Research to determine optimal program structure
  - Mathematical modeling
  - Chlamydia natural history
    - Chlamydia Immunology and Control Expert Advisory Meeting (April 2008)
    - Special JID issue (June 2010)
- Practice-based evidence
  - Community-level assessments
ADDRESSING HEALTH SYSTEM ISSUES, SOCIETAL, AND INDIVIDUAL CHALLENGES

Raul A. Romaguera, DMD, MPH  
*National Chlamydia Screening Coordinator*  
National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention  
NCHHSTP
Health Insurance Status of Women Aged 20-29 Years, 2008

- Private: 57%
- Uninsured: 26%
- Medicaid: 14%
- Other: 3%

CDC, NCHS Data Brief, No 29, February 2010
Health Systems Issues:
Factors that Limit Access to Chlamydia Screening

- **Availability of providers**
  - Providers’ willingness to screen

- **Insurance payment for clinical preventive services**
  - Insurance coverage/adequate reimbursement
  - Medicaid not required to cover preventive services for persons >21 years
    - Unless pregnant or covered by Medicaid family planning waiver

- **Patient utilization**
  - High co-pays and deductibles
  - Access to confidential adolescent health services
Health System Issues: Adolescent Healthcare Visits

- More preventive services recommended for adolescents than any other age group
- Evidence not available for many clinical preventive services recommended for adolescents
- Novel service delivery models are needed
  - Based on scientific evidence and comparative effectiveness research
  - Taking into consideration productivity issues and patient flow
Health System Issues: Adolescents Have Few Preventive Care Visits

Adolescents in Medicaid Receiving a Well-child Check Up During a 2-year Period by Age

Only 46-60% of Medicaid eligible adolescents received a well-child check-up during a 2-year period.
Other Health System Issues: Study of High and Low Performing Plans

- Deductibles and co-pays are still a main barrier
- What the plans do to influence provider behaviors may not be as important as what becomes standard of practice in the community

Increasing public awareness and demand may be better strategy to influence provider behaviors

- Employers’ interest in covering chlamydia screening must be increased
Primary care physicians: Limited knowledge about STDs
- Only 6/10 answered correctly 75% or more of questions representing common STD scenarios

General practitioners’ reasons for low screening
- Lack of information about disease rates in their community
- Belief that their patients are not at risk
- Cannot offer confidential services to adolescents
- Believe chlamydia is not an urgent medical condition; easily treated

Wiesenfeld et al, Sexually Transm Dis 2005
Opportunities Offered by the Patient Protection and Affordable Care Act of 2010

- Increases access to health insurance
- Improves access to clinical preventive services
- Creates incentives to increase utilization of electronic health records
- Increases emphasis on quality of care
Societal Challenges: Stigma

- **Individual: Shame, fear**
  - Stigma about STDs may influence patients’ disclosure of sexual behaviors to healthcare providers

- **Social: People are judged or condemned**

- **Political: Lack of support by politicians and the general public**
Challenges at the Individual Level

- Limited knowledge about the causes of infertility in women
  - Among 12-17 year olds from low-income African-American neighborhood, 58% thought that they had no control over fertility problems
- Low perception of risk among adolescent females

Trent et al, J Adolescent Health 2006
Ethier et al, Sexually Transm Infect 2003
Addressing Challenges at the Individual Level: Partnering with the Media: Get Yourself Tested

- **Partners**
  - CDC, MTV, the Kaiser Family Foundation, and Planned Parenthood

- **The goal**
  - Increase awareness and normalize conversations about STD prevention and sexual health among adolescents and young adults

- **Components**
  - Public service announcements,
  - Videos & “How To” segments for mobile phones
  - Website with digital toolkits, posters, banners, logos, and postcards
  - Tips on ways to generate a conversation about STD testing with health care providers and with sex partners
Community Outreach

Map includes partners in the contiguous United States
Additional partners in Alaska, Hawaii, and U.S. territories not shown

- National Coalition of STD Directors (65 full members)
- CDC Partners (2,600+ kits distributed through 330+ health clinics)
- Planned Parenthood (840+ health centers)
- American College Health Association (115+ health centers)
- mtvU (140+ schools)

4,000 GYT kits distributed to clinics, health centers, community organizations, and others
Legislator Policy Brief on Chlamydia Screening and Treatment

- EPT: Prescribe antibiotics to partners
- Expand screening to women receiving a pregnancy test
- Require health insurance coverage of chlamydia screening
Collaboration with Other National Organizations

National Committee of Quality Assurance
- Assess chlamydia screening coverage
- Develop CT screening measure for accreditation of plans

National Association of Community Health Centers
- Normalize chlamydia screening
- Improve collaboration between centers and departments

Office of Population Affairs and Title X Regional Family Planning Training Centers
- Implement Infertility Prevention Project & provider training

National Chlamydia Coalition (>40 national organizations)
- Address high burden of chlamydial infections in adolescents
- Develop tools and resources for various audiences

CHLAMYDIA PREVENTION AT THE STATE LEVEL: THE CALIFORNIA EXPERIENCE

Gail Bolan, MD
Chief, STD Control Branch
California Department of Public Health
In 1997, chlamydia was the most common communicable disease reported
- Over 75% of cases were seen in the private sector

Public and private providers were interested in developing a chlamydia prevention plan

In 1998, the California Chlamydia Action Coalition was formed and a plan was developed
- Successes
- Remaining challenges and opportunities
California Chlamydia Action Coalition (1998)

- State-wide public-private partnership funded by the California HealthCare Foundation
  - State and local health departments
  - Health care organizations
  - Private providers and professional medical societies
  - Family planning, school-based, and correctional programs
  - Women’s health and community-based organizations
  - Laboratories and university researchers
  - Diagnostic and pharmaceutical companies
  - Policymakers and the public

- **Strategic goals**
  - Increase access to screening
  - Increase partner treatment
  - Promote awareness
  - Enhance health information systems
For health plans, medical groups and provider organizations to

- Educate physicians and patients about chlamydia screening, diagnosis, treatment, and public health laws
- Provide practice guidelines to promote compliance with chlamydia screening and treatment
California Chlamydia Prevention Program Successes

- Increase access to screening
  - Increased screening rates and NAATs utilization
- Increase partner treatment
  - First state to legalize EPT in 2001
- Promote awareness
  - Increased public awareness
- Enhance health information systems
Estimated Chlamydia Screening Coverage (HEDIS)
Females 16–25 Years Old, United States and California, 1999–2008

National California

National Committee on Quality Assurance; California DHCS Division of Medi-Cal Managed Care; Kaiser Permanente Northern CA; California DPH Office of Family Planning and STD Control Branch; Family Planning, Access, Care, and Treatment
## Family PACT Laboratory Services
### FY 07/08

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<th>Test Type</th>
<th>Test Volume</th>
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Partner Treatment

- Expedited partner therapy (EPT) was allowable in 2001
  - Sponsored by health care organizations who had no mechanisms to easily treat partners outside of the health plan
  - Set forth exceptions to the laws that require examination before prescribing

- Prior to 2001, traditional partner referral was used
  - Health department follow-up of partners was rare because of low staffing levels and large number of cases
Provider Barriers to EPT, CA 2002

- Incomplete care for partner
- Dangerous without knowing hx
- Practice not paid for
- May get me sued
- Partners name must be provided
- Only for male partners

Strongly agree/agree (%)

Packel LJ et al, Sex Trans Dis 2006; 33:458-463
NP, Nurse practitioner
Partner Management Strategies Offered in Family Planning Clinics, CA 2005-2006

- Traditional partner referral 52%
- BYOP 17%
- EPT 17%
- None 9%
- Missing 4%

BYOP, Bring your own partner
Patient-Report That Partner Received Treatment, by Partner Management Strategy Offered

By Patient-reported Management Strategy

- Overall (n=957): 51%
- EPT (n=172): 80%
- BYOP (n=172): 78%
- Partner Referral (n=518): 44%

BYOP, Bring your own partner
Chlamydia Community Awareness and Health Promotion Activities

- Established partnerships with youth-serving agencies
- Improved interagency communication and sharing of resources
- Co-founded the California Adolescent Sexual Health Work Group
- Developed social marketing projects
  - Youth Encouraging Safer Sex (YESS!)
  - Hookup Text Messaging
  - Youth Social Marketing Toolkit
Sexually Transmitted Diseases (STDs): What you need to know to stay healthy

STD 101 for Teens

California STD/HIV Prevention Training Center, www.stdhivtraining.org
Changes in Educators Confidence in Various Skills after STD Training Activities, 2009

STD Community Intervention Project on-line survey of 396 community educators serving over 200,000 youth in 11 high priority local health jurisdictions in California
Prepared by California Department of Public Health STD Control Branch
Chlamydia Prevention at the State Level: Remaining Challenges

- High Medicaid reimbursement rates of NAATs screening tests
- No federal reimbursement for EPT
- Competing priorities
- Declining public health infrastructure
Gale R. Burstein, MD, MPH, FAAP, FSAHM
Adolescent Medicine Physician
University at Buffalo Pediatrics Associates
Buffalo, New York

DISCLOSURE: Dr. Burstein has received honoraria from Merck Inc. and GlaxoSmithKline for speaking and consultancy engagements
Strategies to Change Provider Practices to Consistently Screen for Chlamydia

- Training medical professionals
- Endorsing screening by professional medical associations
- Developing tools to facilitate office-based chlamydia screening
- Disseminating information
- Promoting quality measures to improve care of adolescents
  - NCC: New chlamydia screening measure for accreditation of commercial and Medicaid plans - effective in 2010
  - AAP, American Board of Pediatrics: Chlamydia screening quality improvement activity as part of the recertification in adolescent medicine
Collaboration with Professional Organizations and Health Plans

Chlamydia and STD Resources for Healthcare Providers

Why Screen for Chlamydia?
An Implementation Guide for Healthcare Providers

- Reduces pelvic inflammatory disease (PID)
- Reduces infertility, ectopic pregnancy, and chronic pelvic pain
- Prevents complications in newborns

http://ncc.prevent.org/providers.html
Providing Confidential Sexual Health Care Services

- All states and the District of Columbia currently allow minors to consent for STD diagnosis and treatment
  - No state requires parental consent
- An explanation of benefits (EOB) listing services rendered and reimbursed by the health plan may be sent to the primary insured
  - EOB may disclose confidential services
- AAP and SAHM developed billing/coding guidance to minimize billing statement disclosures

AAP, American Academy of Pediatrics, www.aap.org
SAHM, Society for Adolescent Health and Medicine, www.adolescenthealth.org
Tools to enhance confidential service delivery (AAP and SAHM)
- “Atraumatic parentectomy”

Disclosure of confidential services through health plan billing statements (AAP and SAHM)

Disclosure of confidential services through billing (AAP NYS Chapter and CDC’s Infertility Prevention Project in NYS)
Implementing Expedited Partner Therapy (EPT)

- **CDC partners’ formal endorsement**
  - SAHM and AAP: Position paper supporting EPT

- **Developing tools to assist states interested in removing legal and health systems barriers**
  - Professional medical organizations, CDC and the Public Health Law and policy Program

- **Advocacy in legislative and policy development at the state level**
  - AAP, SAHM, and ACOG

- **Planning to work with CMS and HRSA to assure coverage of all EPT services in states where EPT is legal**
Evolving Landscape of EPT: Legal Status at the State Level

- EPT is Permissible
- EPT is Potentially Allowable
- EPT is Likely Prohibited
- Legislation Pending
Addressing Health Disparities of Chlamydia

- NCC diverse membership attempts to partner with organizations serving minorities, women, and youth
- 10 small grants to develop community-level prevention approaches aimed at increasing chlamydia screening among those populations at risk
Chlamydia Prevention: Summary

- **Chlamydia is a major preventable cause of infertility**
- **Effective prevention interventions are under-utilized**
- **Programs having some effect, but need to do better by**
  - Increasing screening, partner treatment (EPT), and awareness
  - Reaching disproportionately-affected populations
  - Improving measurement
- **Many challenges, but also opportunities**
  - Progress in addressing public health, societal and individual challenges
  - Health care reform: Engagement in evolving health care delivery systems to address barriers at federal, state, and local levels