

STD SCREENINGS AND DATA

OBJECTIVES

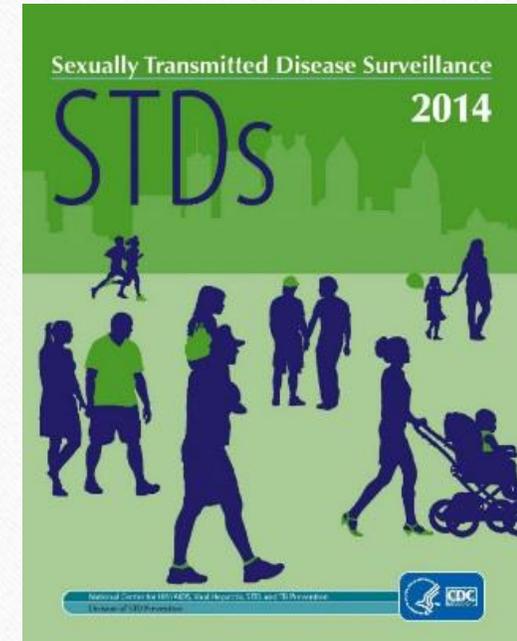
1. Identify barriers and challenges in screening for STDs within family planning clinics
2. Identify strategies to increase screening rates for Chlamydia/Gonorrhea for all sexually active females < 25 years of age
3. Identify strategies to increase screening rates for HIV, Hepatitis C and Syphilis in family planning clinics

2014 Surveillance Report

CDC's annual STD report finds overall reported cases for Chlamydia, gonorrhea and syphilis are increasing

Young people are still at the highest risk of acquiring a STD

Greater awareness and action is needed at all levels to ensure good health for youth and others disproportionately impacted by STDs



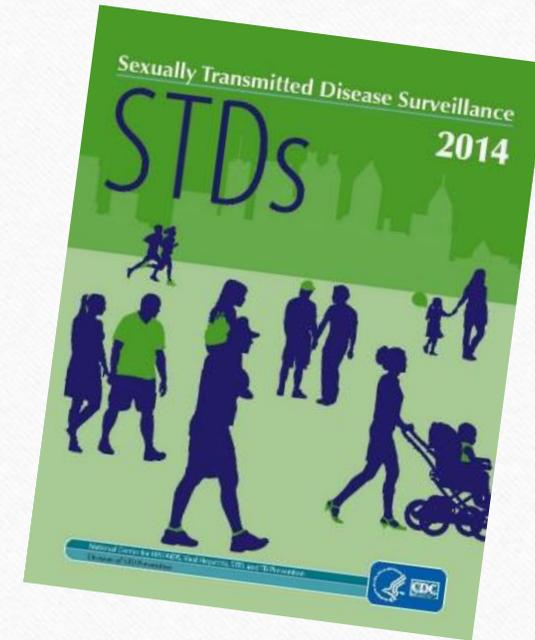
Overview: Case rate increases seen from 2013-2014

- **Chlamydia: 2.8% increase**
 - 6.8% increase among men
 - 1.3% increase among women

- **Gonorrhea: 5% increase**
 - 10.5% increase among men
 - 0.4% decrease among women

- **Primary & Secondary syphilis: 15.1% increase**
 - Increases seen in MSM, MSW, women
 - MSM accounted for 83% of P & S cases

- **Congenital syphilis:**
 - Decreased from 2008-2012, then rose by 27.5% in 2014
 - Increases in all regions with largest increases in the NE and West



Assess all clients for risk of sexually transmitted infections without regard to age

Sexual History - one strategy for eliciting information is the **5 P's**

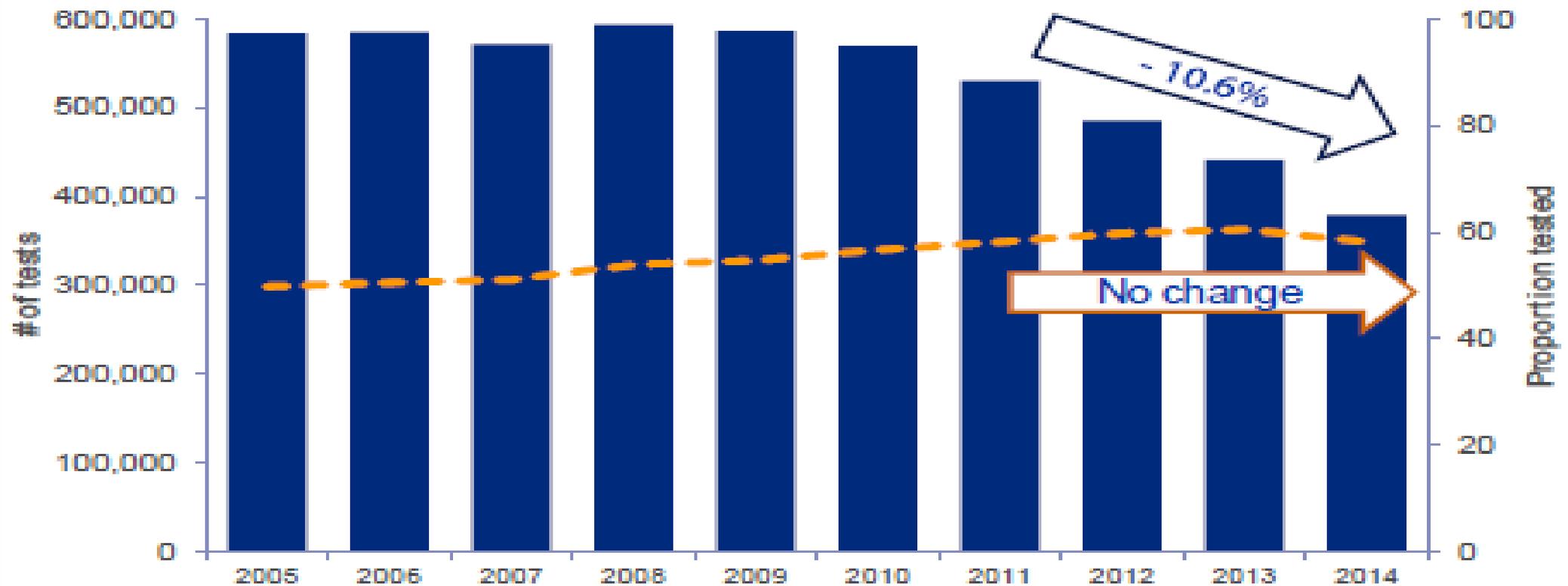
1. Partners
2. Practices
3. Prevention of pregnancy
4. Protection from STDs
5. Past History of STDs

CHLAMYDIA and GONORRHEA

Chlamydia and Gonorrhea Screening Guidelines

- ❖ Annual screening of sexually active women < 25 years of age
- ❖ Screening of older women at increased risk
 - New Sex partner,
 - Partner with concurrent partners or
 - More than one partner, or
 - Partner with an STI

Number of female family planning users aged 15–19 years tested for chlamydia and proportion tested, Title X Family Planning, 2005–2014



Chlamydia screening for female clients <25 years

Statewide CVR data (RH Program data)

	FY2015	FY2016
CT test (medical service) marked on CVR at least once	53.9%	44.7%
Date of last CT test (on CVR) within 1 year of visit	52.9%	50.4%

13A. CONT. MEDICAL SERVICES (Check all Applicable)

STD Related Services

- 11 - Vaginitis/Urethritis/Eval/Dx
- 12 - Vaginitis/Urethritis/Eval/Rx
- 29 - Chlamydia Test
- 13 - Chlamydia Treatment
- 14 - Chlamydia Presumptive Rx
- 15 - Wart Treatment
- 16 - Herpes Test
- 28 - Gonorrhea Test
- 30 - Wet Mount
- 43 - HIV Test Standard
- 44 - HIV Test Rapid
- 47 - VDRL/RPR
- 50 - HPV Test

7a. CLIENT'S TEST DATES - Females Only

1 - Last Chlamydia (≤ 24)
 1 Never
 2 Unk.
 3 Date

MO.	YR.

2 - Last Pap (≥ 21)
 1 Never
 2 Unk.
 3 Date

MO.	YR.

Clients with 'Never' and 'Unk' previous CT test dates – do they get tested?

7a. CLIENT'S TEST DATES - Females Only

1 - Last Chlamydia (≤ 24)	<input type="checkbox"/> 1 Never	<input type="checkbox"/> 2 Unk.	3 Date	MO.	YR.
2 - Last Pap (≥ 21)	<input type="checkbox"/> 1 Never	<input type="checkbox"/> 2 Unk.	3 Date	MO.	YR.

?

3A. CONT. MEDICAL SERVICES (Check all Applicable)

STD Related Services

<input type="checkbox"/> 11 - Vaginitis/Urethritis/Eval/Dx	<input type="checkbox"/> 16 - Herpes Test
<input type="checkbox"/> 12 - Vaginitis/Urethritis/Eval/Rx	<input type="checkbox"/> 28 - Gonorrhea Test
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<input type="checkbox"/> 14 - Chlamydia Presumptive Rx	<input type="checkbox"/> 44 - HIV Test Rapid
<input type="checkbox"/> 15 - Wart Treatment	<input type="checkbox"/> 47 - VDRL/RPR
	<input type="checkbox"/> 50 - HPV Test

- Statewide, during CY15, only 16% of clients with 'Never' or 'Unk' previous CT test dates had a CT test marked on that CVR.
- Caveats:
 - Data defaulted to 'Unk' if blank during CY15
 - By agency, the % tested ranged from 0% to 66%
 - We'll keep track of this in future years!



overcoming barriers

Barriers and Challenges



Barriers

For Clients

1. Knowledge of STDs and consequences
2. Concern over costs, fear getting a bill
3. Confidentiality

For Providers

1. Marking the CVR
 - if dates are unknown or never – screen client
2. Client centered care – possible missed opportunities for screening



IMPROVING CHLAMYDIA SCREENING

1. Screenings are “opt out” instead of “opt in” by making it a “routine” process
2. Provide tools for providers to remind them to mark the CVR
3. Include in EHR as a “must do” before you can close the program
4. Provide educational materials; placing posters in bathroom, exam rooms and in waiting room on the importance of screening for STDs



Testing is the only way to know if you have an STD.

#STDMONTH16 talk.test.treat. #TalkTestTreat

15-24 year olds account for half of all new STD Infections

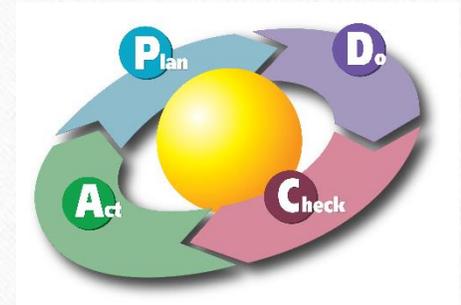


Talk openly to your partner(s) and your doctor about sexual health and STDs.

#STDMONTH16 talk.test.treat. #TalkTestTreat

IMPROVING CHLAMYDIA SCREENING (cont.)

5. Annual staff trainings on the importance of STD screening
6. Develop a QI process for clinic efficiency on STD screenings
7. Send preventive health screening card/text/emails to remind clients when preventive services are due.



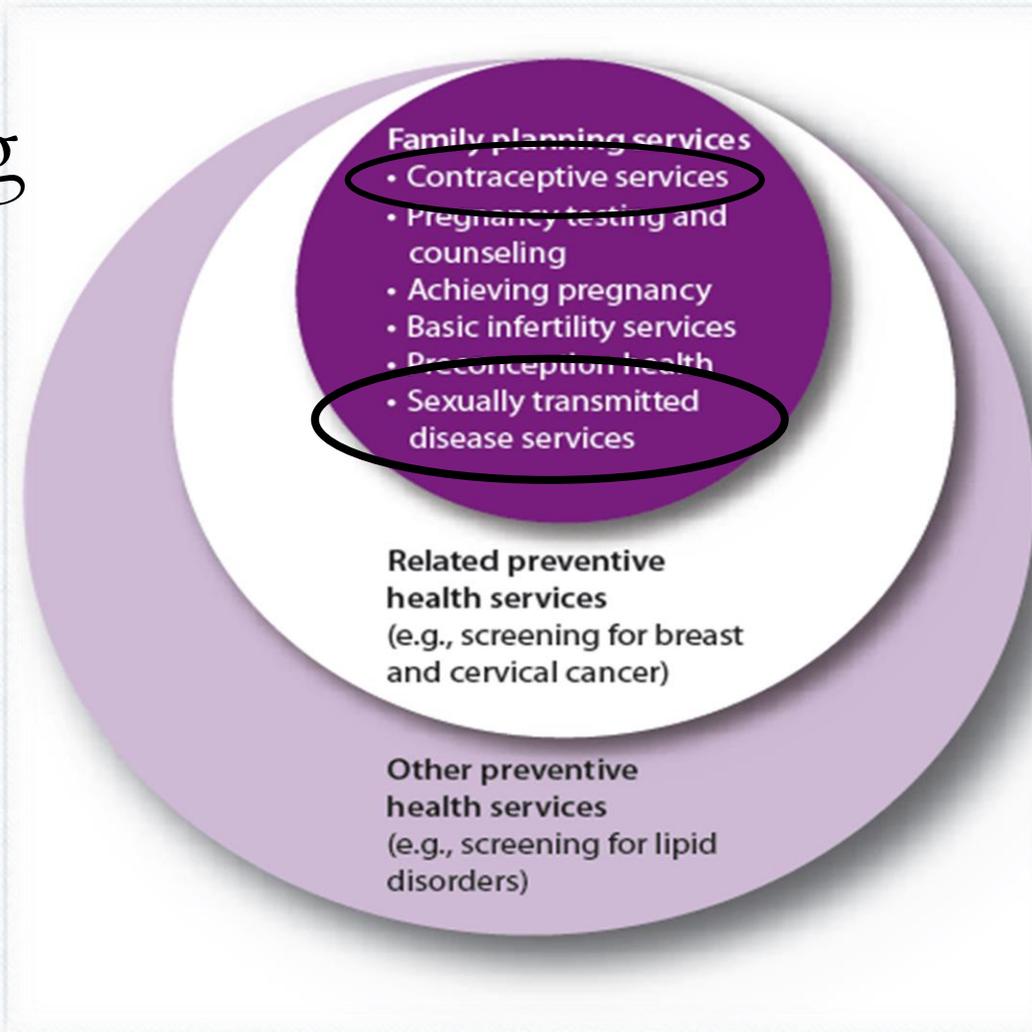
Which of the following is considered **Core Requirement(s)** for family planning services according to the QFP?

- A. Cervical Cancer Screenings
- B. Contraceptive services
- C. Sexually Transmitted Diseases
- D. B & C
- E. All of the above



QFP - Family Planning Core requirements

Answer is D



CDC STD Testing and Treatment Guidelines

Routine Screening

Chlamydia and Gonorrhea - for all women < 25 years of age

HIV - once for individuals 15 – 65 years of age

Hepatitis C – a one time screen for individual born between 1945-1965

Syphilis – screen individuals at increased risk

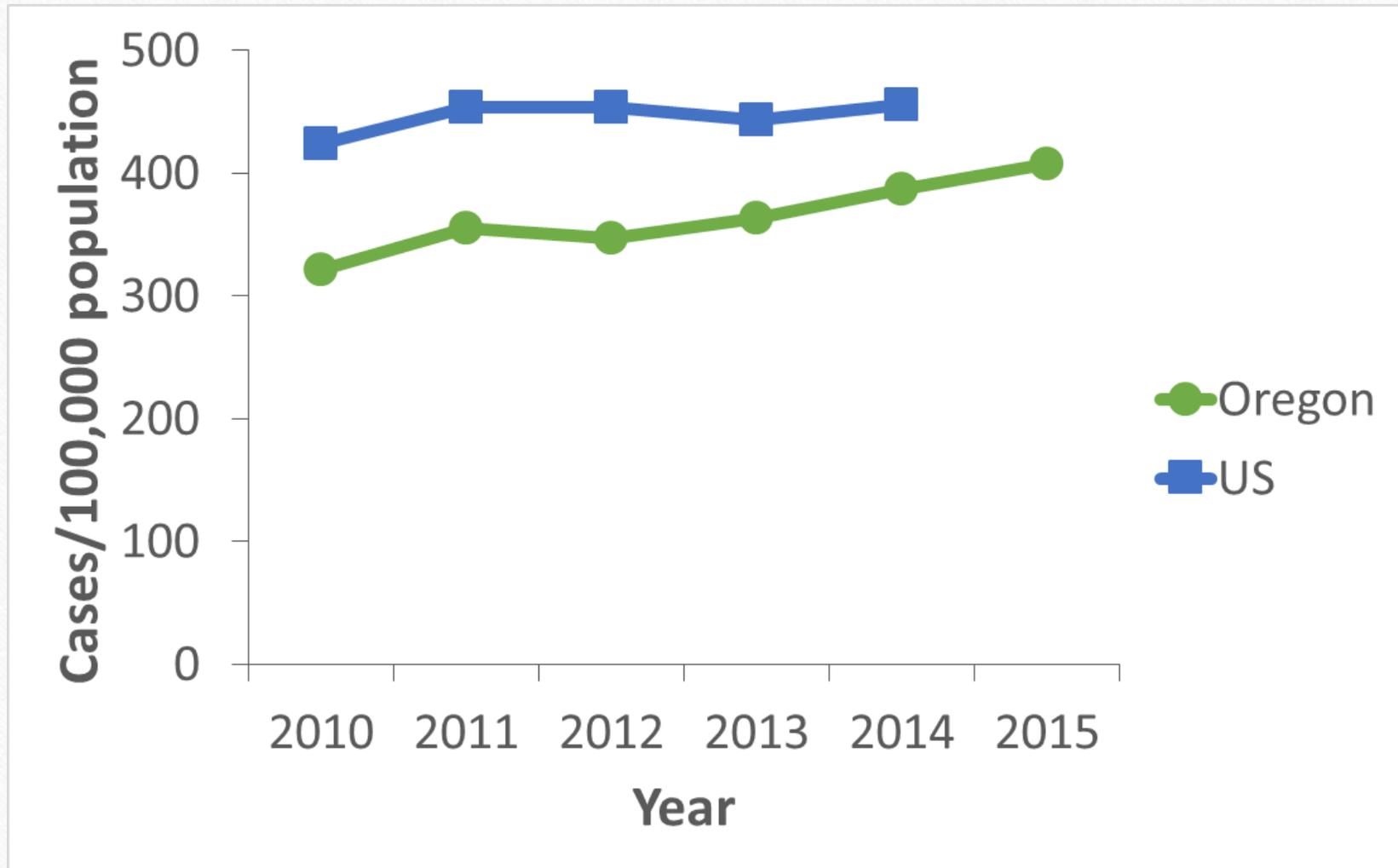
Hepatitis B – screen individuals at increased risk

Updates from HIV/STD Prevention Programs

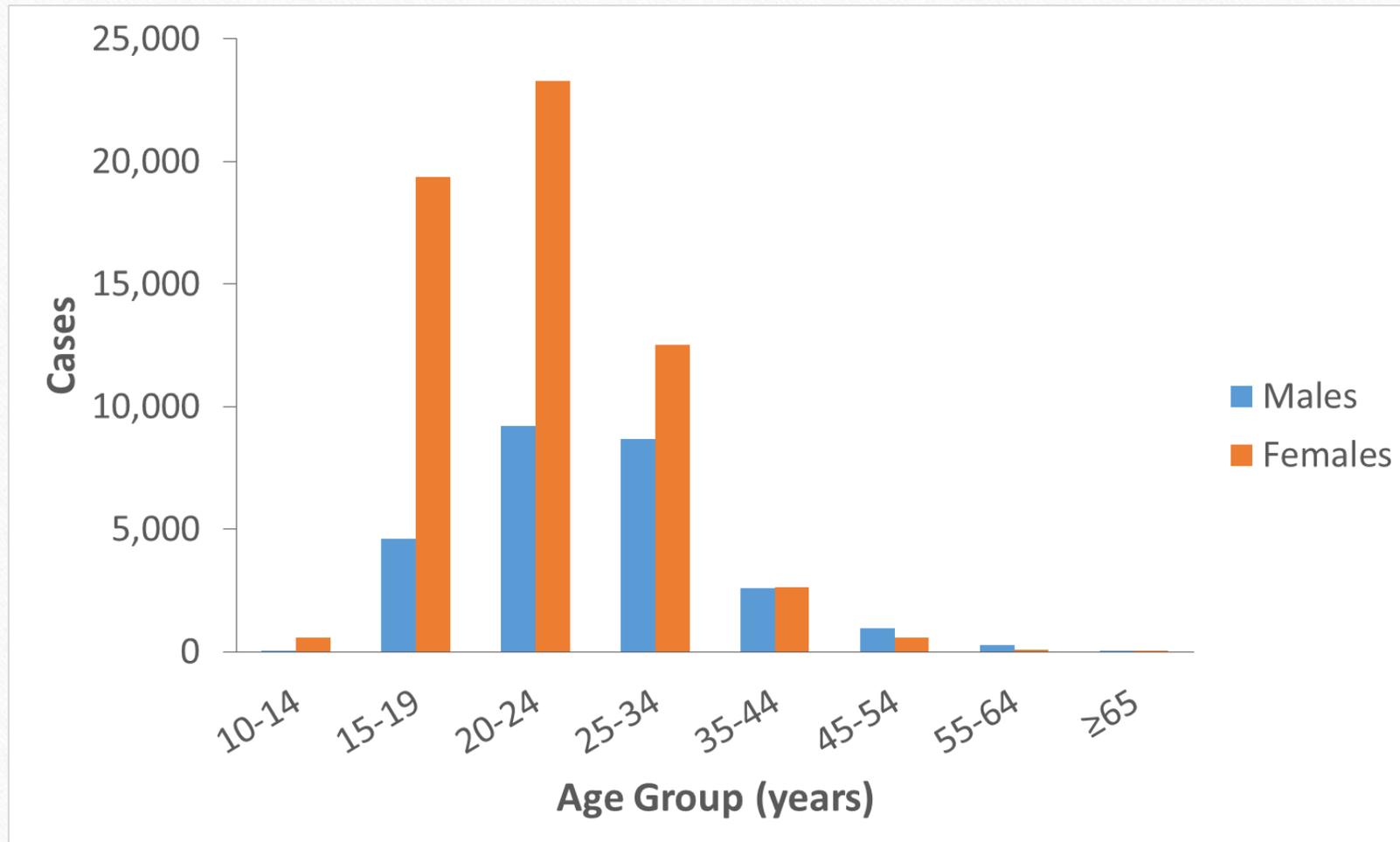
Josh Ferrer
STD/HIV Prevention Technical Consultant



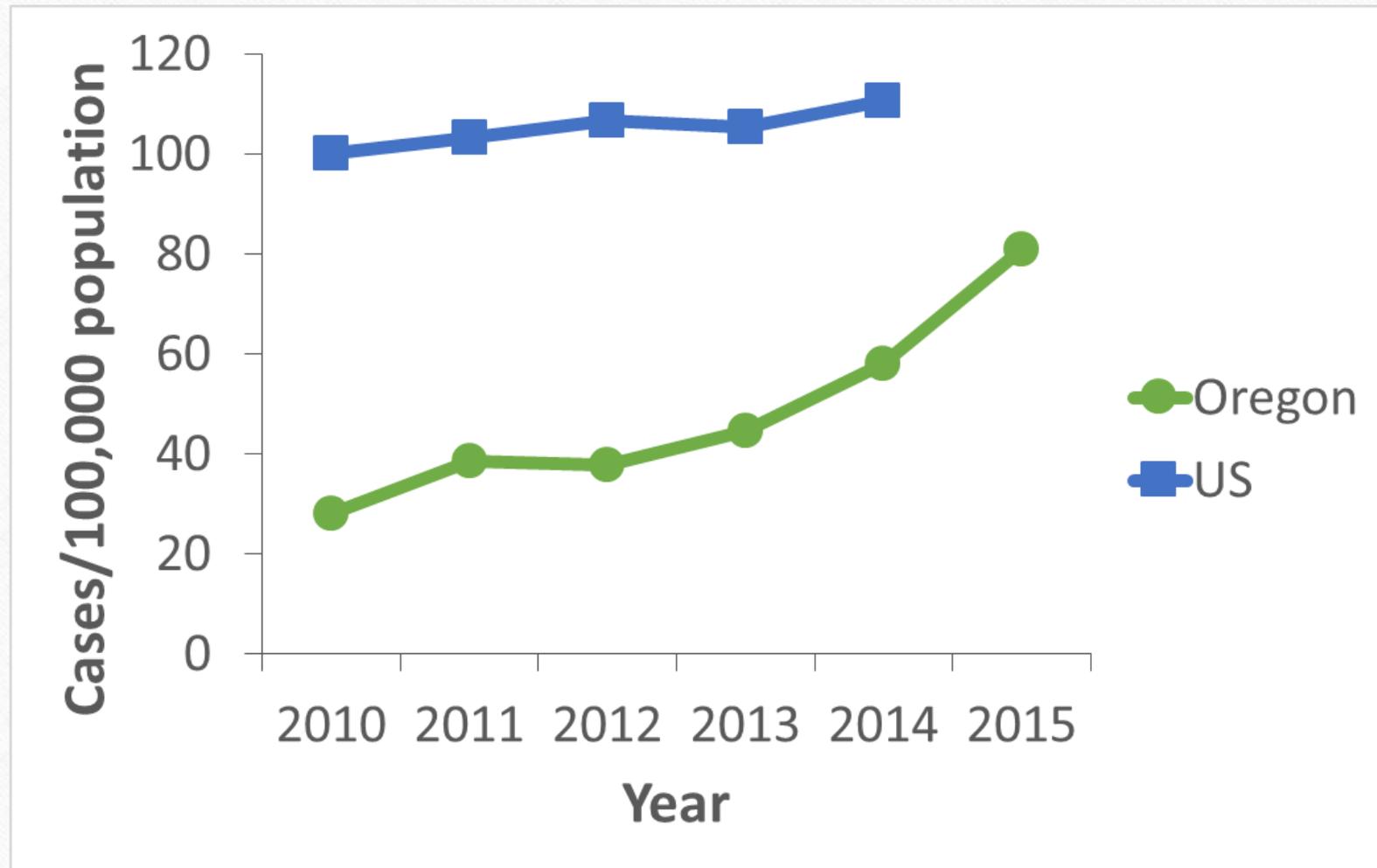
Reported Chlamydia cases, Oregon 2010–2015



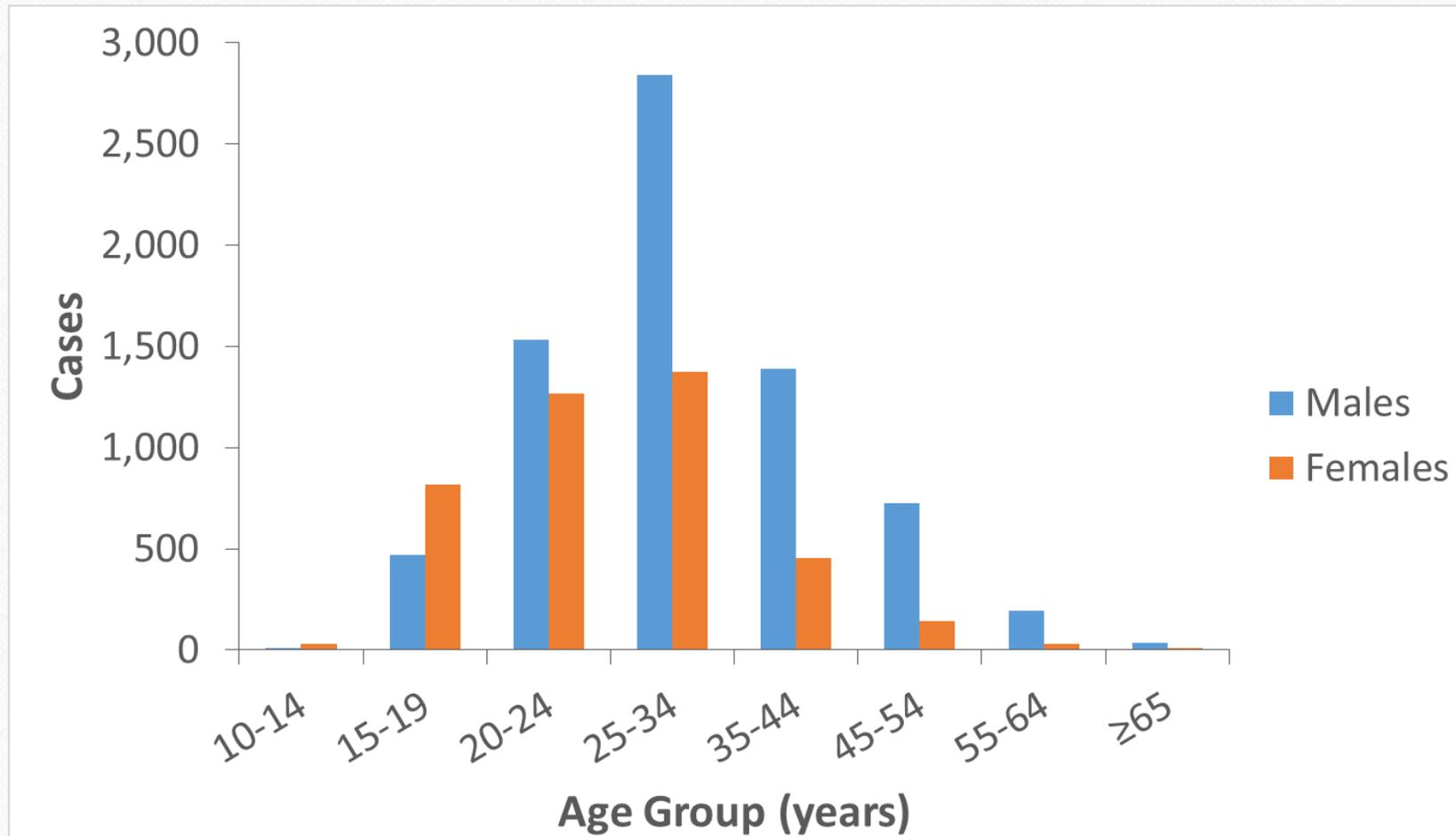
Cumulative Reported Cases of Chlamydia by age group, Oregon 2010–2015



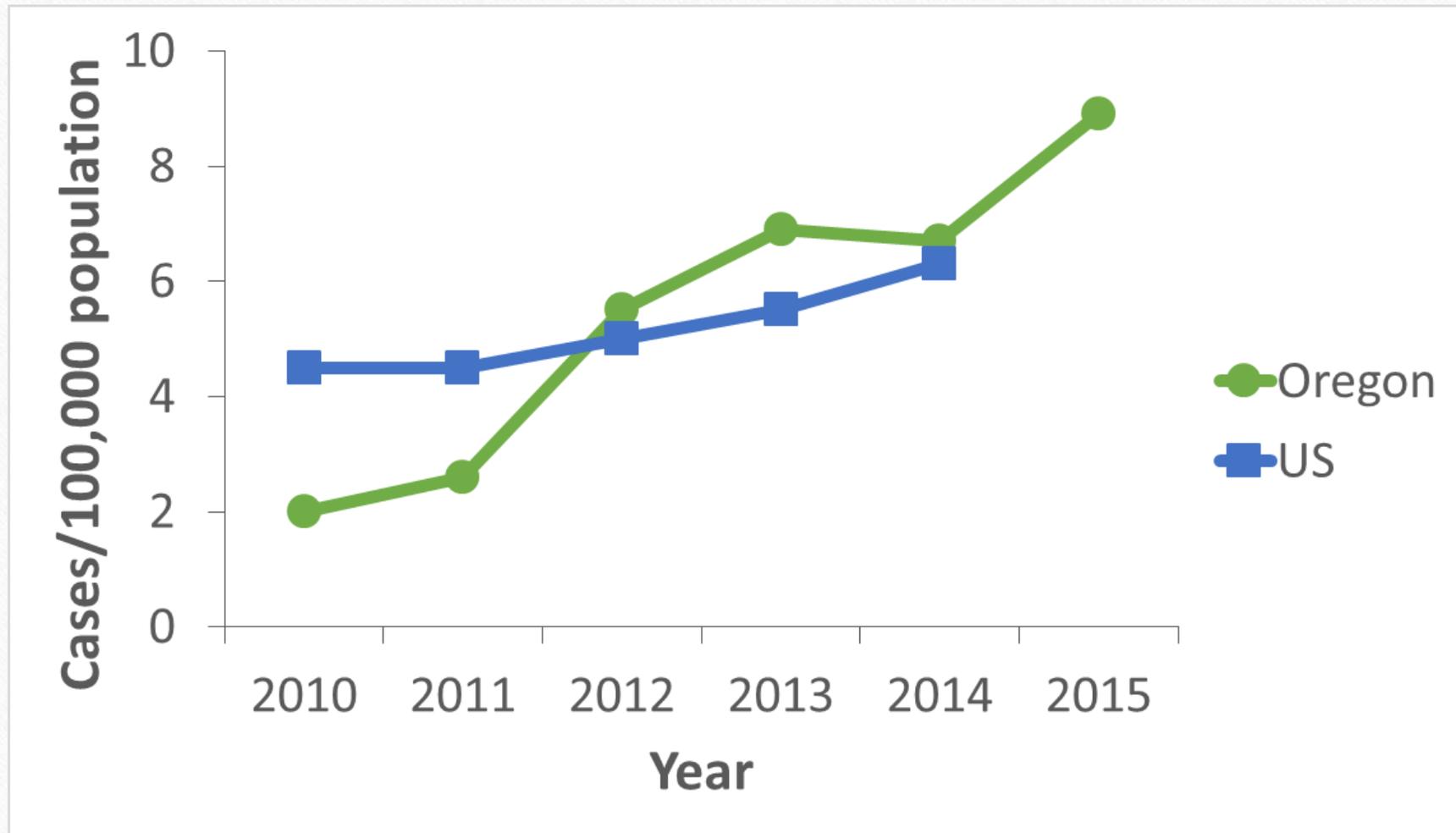
Reported Gonorrhea Cases, Oregon 2010–2015



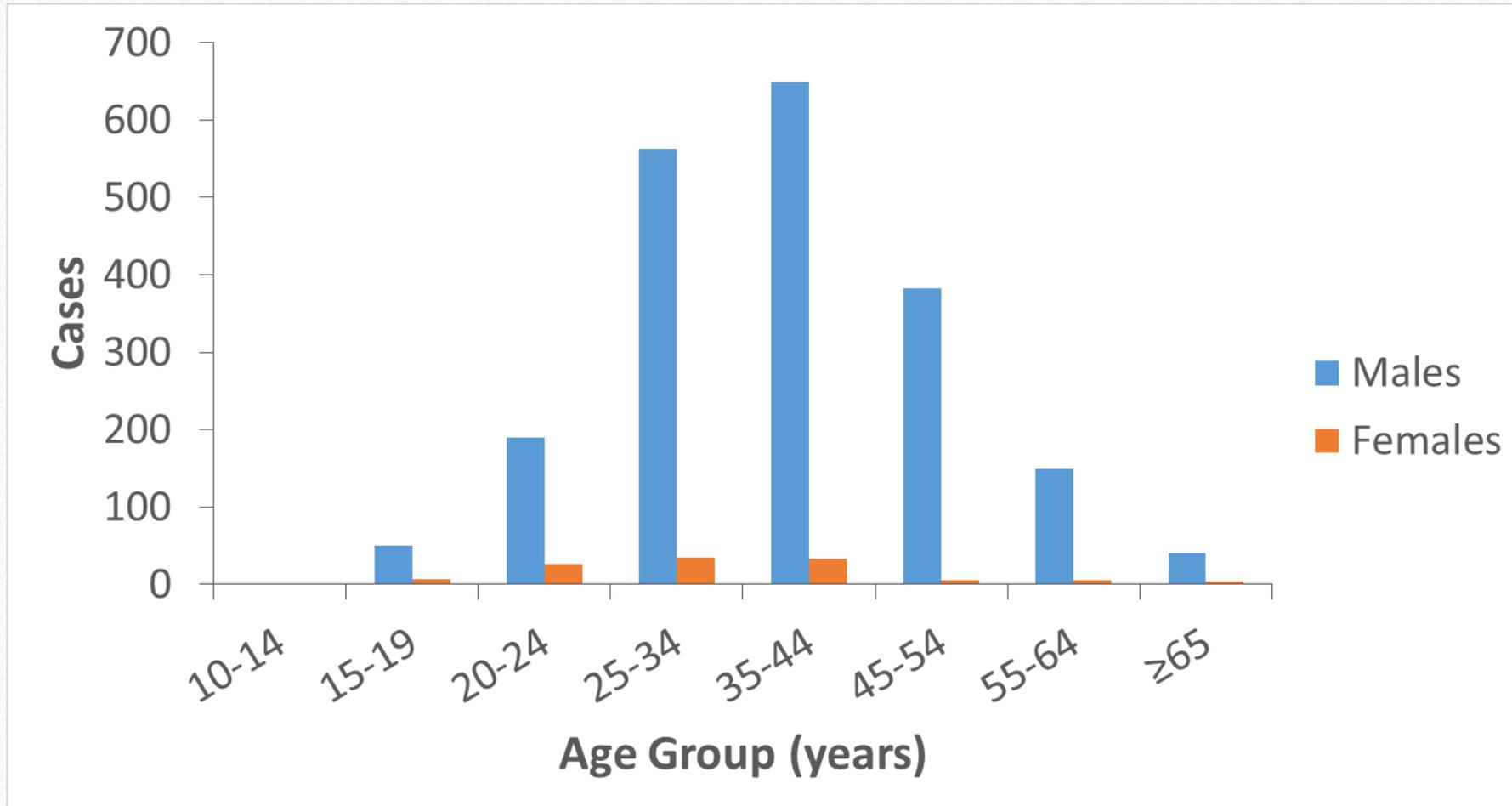
Cumulative Reported Cases of Gonorrhea by age group, Oregon 2010–2015



Reported Primary & Secondary Syphilis Cases, Oregon 2010–2015

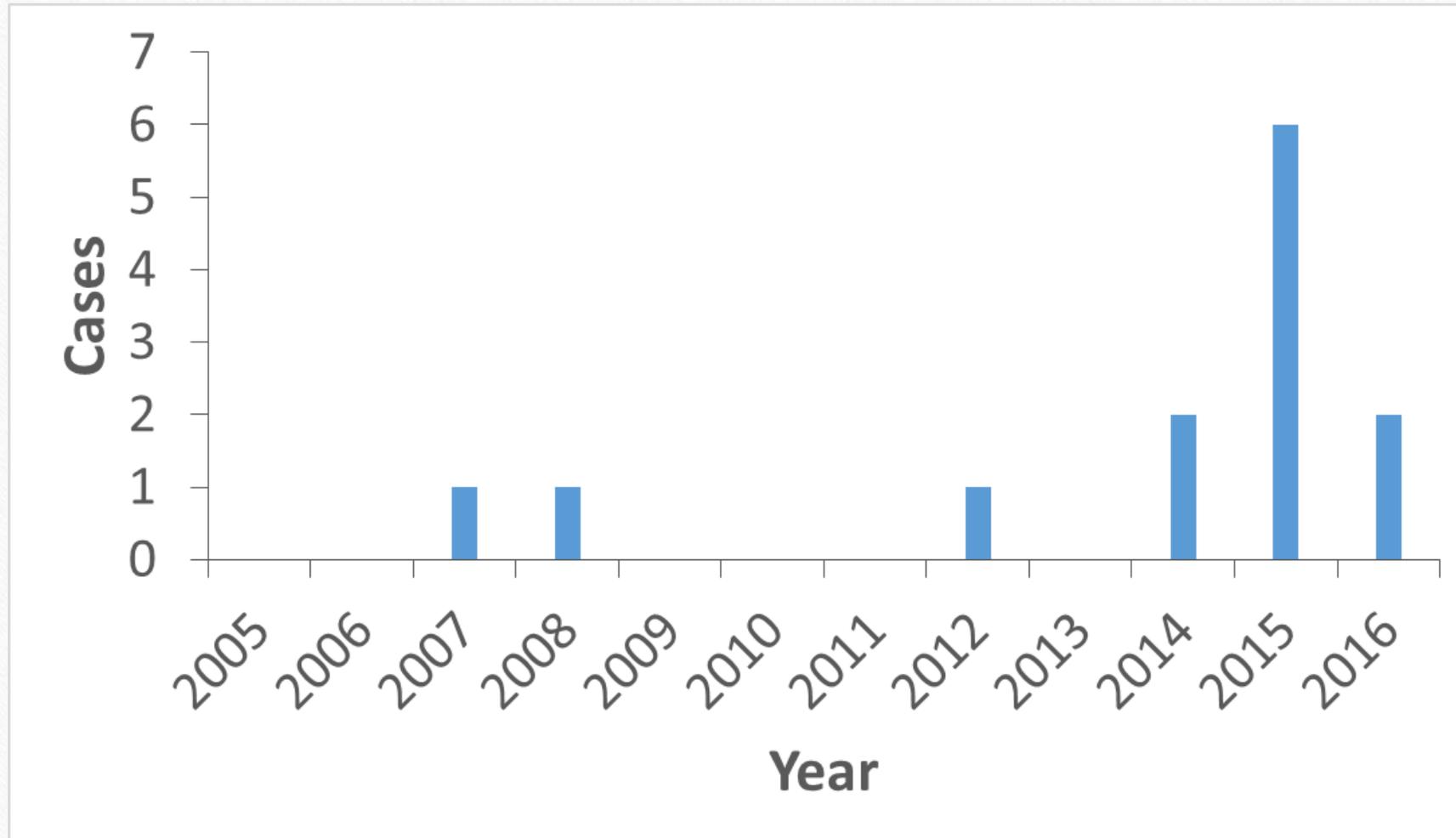


Cumulative Reported Cases of Early Syphilis* by age group, Oregon 2010–2015



*includes primary, secondary, and early latent stage infection

Congenital Syphilis Cases, Oregon 2005–April 2016



Syphilis Screening

- Recommendation is to screen “individuals at risk”
 - What does that mean?

PORTLAND

nationally we're...

#1 for coffee

#1 for fitness

#5 for syphilis



Oregon
Health
Authority
Centers for Disease Control and Prevention-Funded Campaign

GET INFORMED

SyphAware.org

SYPHILIS

It doesn't burn,
but it can cause a
painless sore, rash
and more.



**GET
INFORMED**

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Syphilis Screening

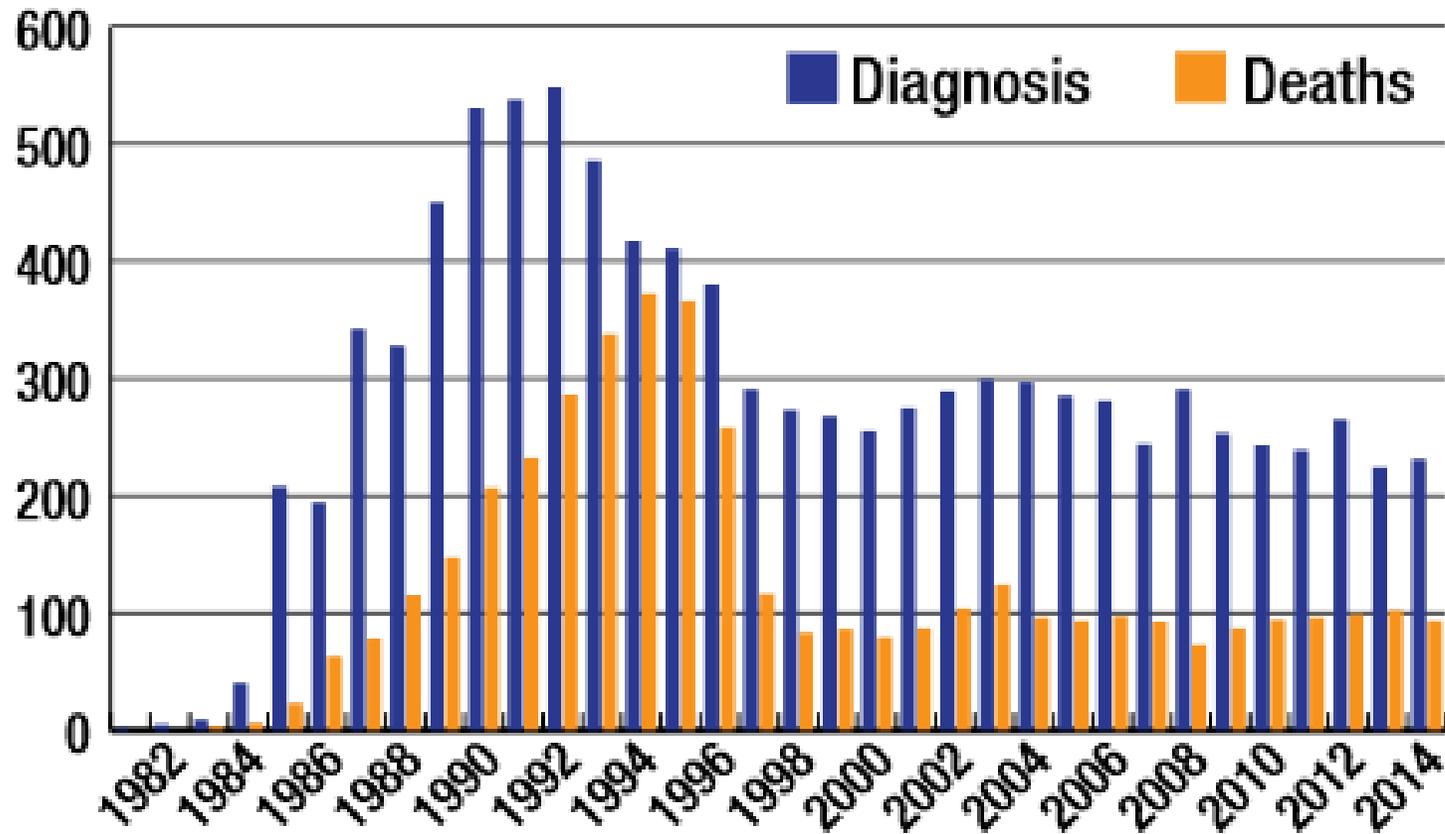
Who needs to be screened	How often should screening be done?
<ul style="list-style-type: none">• Men who have sex with men• People with HIV• People of either sex who use illicit drugs including, but not limited to, methamphetamine, opioids, and cocaine• People of either sex who engage in sex work or exchange sex for money or other things of value• People who have or have had other bacterial or viral sexually transmitted infections• People who have been exposed to syphilis	<ul style="list-style-type: none">• At least annually for all the groups listed regardless of condom use or number of partners• Every three months if sexually active with multiple partners

Gonorrhea Drug Resistance

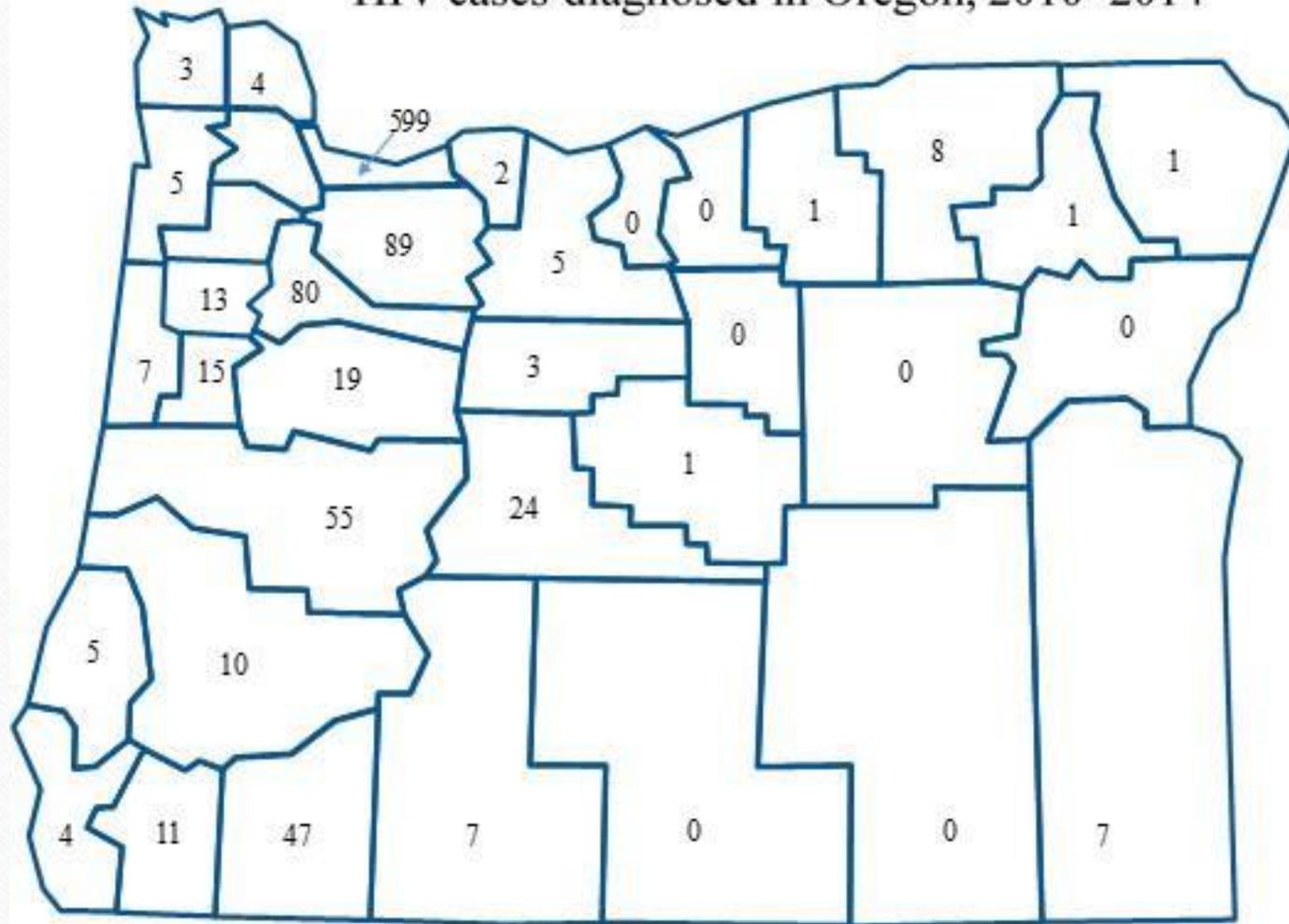
- The threat of drug resistant gonorrhea is a major concern.
- Individuals should be treated with the CDC-recommended dual therapy:
 - Ceftriaxone 250mg IM in a single dose - PLUS-
 - Azithromycin 1g orally in a single dose
- Report suspected cases of drug resistant gonorrhea to your local county or state health department.

www.cdc.gov/std/gonorrhea/arg

HIV cases diagnosed in Oregon and HIV cases who have died in Oregon, 1981–2014



HIV cases diagnosed in Oregon, 2010–2014



True or False?

- Under Oregon law, a separate written consent for HIV testing is required.

Consent for HIV Testing

- Under Oregon law, a separate written consent for HIV testing is required.
 - *FALSE*
- Previously Oregon law required special informed consent for HIV testing.
- Senate Bill 1502 passed in 2012 removed this requirement.

Consent for HIV Testing

- Now patients must be:
 - Notified testing may occur
 - Given the opportunity to decline if they wish
- Notification may be done in any of the following ways:
 - Verbally through health care provider or their designee
 - In writing through a general medical consent form, brochure, fact sheet, or signage in a waiting area

Oregon Revised Statute 433.045 (§3)

Oregon Administrative Rule, Chapter 333, Division 22, Section 0205

Consent for HIV Testing

- The following language is compliant with the law and could be inserted into a general medical consent form:

You may be tested for HIV. If you want to decline HIV testing, check this box [].

- This one of several acceptable approaches you could use.
- You are free to decide what procedure will work best for your practice as long as the patient is notified testing may occur and allowed to decline.

True or False?

- HIV testing must be accompanied by a counseling session (sometimes referred to as pre- or post-test counseling)?

True or False?

- HIV testing must be accompanied by a counseling session (sometimes referred to as pre- or post-test counseling)?
 - *FALSE*
- The CDC has moved away from its recommendation that counseling accompany each HIV testing event in non-clinical settings.
- Goal is to decrease time and resources necessary to make testing simpler, easier, and more routine.

HIV Testing Process

Individual *Rapid* HIV Testing Protocol

1	Introduce and Orient Client to Session
2	Prepare For and Conduct Rapid HIV Test <i>(10-20 minute read time)</i>
3	Conduct Brief Risk Screening
4	Provide Initial Results and Follow Protocol for Confirmatory Testing
5	Develop Care, Treatment, and Prevention Plan Based on Results
6	Refer and Link with Medical Care, Social and Behavioral Services

Individual *Nonrapid* HIV Testing Protocol

INITIAL VISIT	
1	Introduce and Orient Client to Session
2	Conduct Brief Risk Assessment
3	Prepare For Test and Collect Sample
RETURN VISIT <i>(ideally no more than 1 week from initial visit)</i>	
4	Check-In With Client
5	Provide Confirmed Results
6	Develop Care, Treatment, and Prevention Plan Based on Results
7	Refer and Link with Medical Care, Social and Behavioral Services

Questions?



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