

WHY SCREEN FOR CHLAMYDIA?

A How-To Implementation Guide for Healthcare Providers



Early identification and treatment:

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



Why Screen for Chlamydia? A How-To Implementation Guide for Healthcare Providers, 3rd Edition was developed with assistance from the Provider Education Committee of the National Chlamydia Coalition.

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| Aetna – Northeast & Mid-Atlantic Region | National Institute for Health Care Management Foundation |
| American Academy of Pediatrics | National Network of Prevention Training Centers |
| American College Health Association | Pennsylvania Department of Health |
| American College of Nurse-Midwives | Physicians for Reproductive Health |
| American College of Obstetricians and Gynecologists | Planned Parenthood Federation of America |
| California Department of Public Health | Society for Adolescent Health and Medicine |
| International Union against Sexually Transmitted Infections | The National Alliance to Advance Adolescent Health |
| Maryland Department of Health and Mental Hygiene | The National Association of Nurse Practitioners in Women's Health |
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Why Screen for Chlamydia? A How-To Implementation Guide for Healthcare Providers, 3rd Edition includes the latest information and resources to:

- ▶ Take a sexual history
- ▶ Improve delivery of chlamydia screening and retesting
- ▶ Make screening for and treating chlamydia routine practice
- ▶ Provide confidential care to adolescents

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Introduction to Chlamydia Screening

The consequences of chlamydial infection fall predominately on females and their infants.

Therefore, chlamydia screening in females is an important measure of quality of care. Chlamydia screening in women has been a HEDIS (Healthcare Effectiveness Data and Information Set) measure since 2000. Health plans must report their chlamydia screening rates in order to gain or maintain accreditation from the National Committee on Quality Assurance (NCQA). It is also part of NCQA's accreditation program for Accountable Care Organizations. Additionally, it is part of the core sets of quality measures for both Medicaid and the Children's Health Insurance Program.

Despite chlamydia screening being a core measure of quality health care,

screening rates remain suboptimal. This guide outlines effective strategies for increasing rates of both initial screening for chlamydial infection and retesting after treatment. Although chlamydia and gonorrhea screening often occur concurrently, this guide focuses on chlamydia screening.

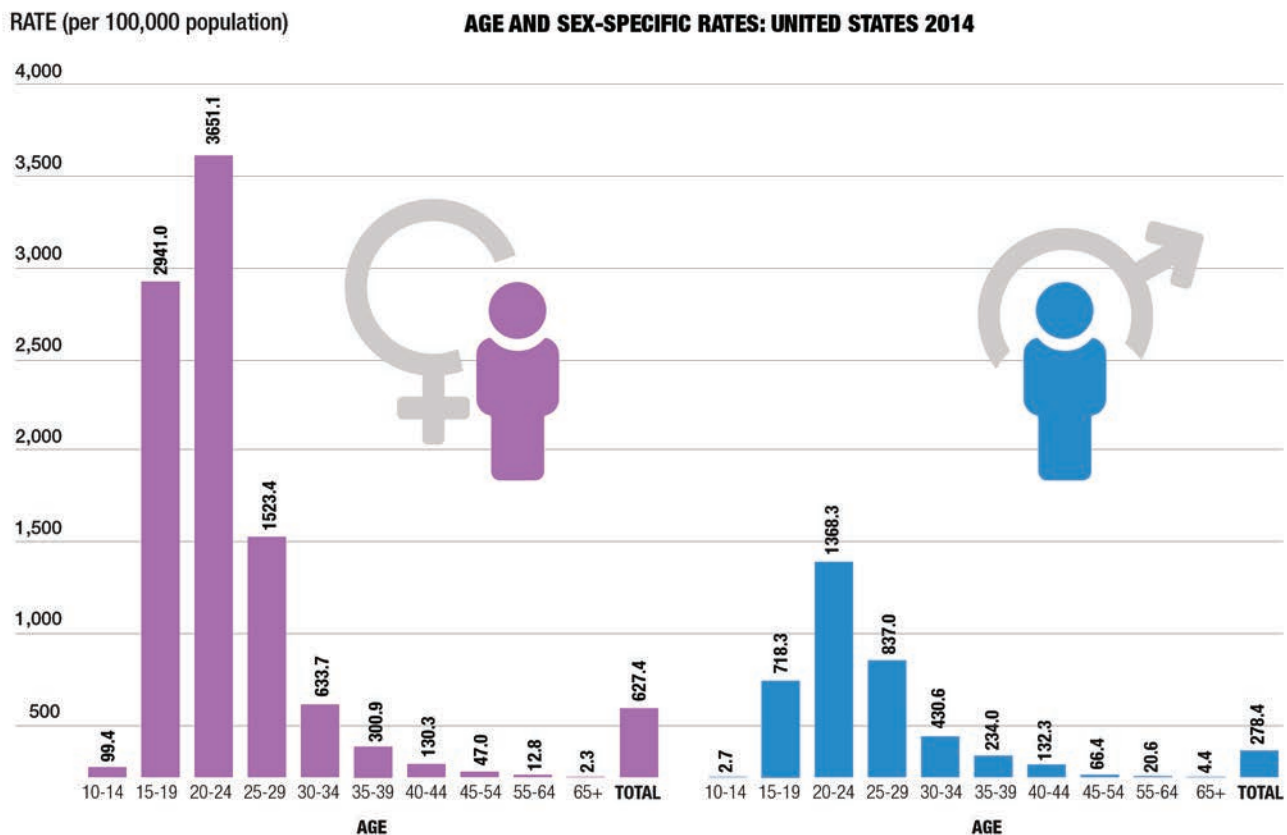
REASONS TO SCREEN FEMALES FOR CHLAMYDIA

- ▶ Chlamydial infection is very common among young people. Figure 1 illustrates that sexually active females aged 20-24 years have the highest rate of infection, followed closely by adolescent females aged 15-19.
- ▶ Untreated chlamydial infection is the leading preventable cause of tubal

factor infertility in the U.S. Infection may also cause pregnancy complications, such as early labor, and infants can be infected during birth leading to conjunctivitis and pneumonia.

- ▶ It is estimated that lifetime direct medical costs for chlamydia were \$516,700,000 (in 2010 dollars).
- ▶ Most cases are asymptomatic and symptoms, when present, are vague. Due to chlamydia's asymptomatic nature, screening is required to detect infection.
- ▶ Chlamydia screening is a high-value, but underused preventive service. The National Commission on Prevention Priorities (NCPPI) found that 30,000 cases of pelvic inflammatory disease could be averted annually if 90% of eligible women were screened.

1 Rates of Chlamydial Infection



Source: Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance, 2014. Atlanta, GA: U.S. Department of Health and Human Services; 2015.

CHLAMYDIA SCREENING RECOMMENDATIONS

Females aged 24 and younger. Screen all sexually active females aged 24 and younger at least annually. Screen those who are at risk more frequently. Risk factors include having a new partner, more than one partner, a partner who has concurrent partners, or a partner who has an STI. This recommendation is supported by the Centers for Disease Control and Prevention, the U.S. Preventive Services Task Force, and many leading medical associations. See [Resource 1](#).

Females over age 24. Screen sexually active females over age 24 if they are at increased risk for infection. Risk factors include having a new partner, more than one partner, a partner who has concurrent partners, or a partner who has an STI.

Pregnant females. Screen all pregnant females aged 24 years and younger, and pregnant females over age 24 who have risk factors, at their first prenatal visit. Retest during the third trimester to prevent infection of the infant and postnatal complications. Pregnant women who have chlamydial infection should have a test-of-cure 3–4 weeks after treatment and then be retested within 3 months.

Women Who Have Sex with Women (WSW). Screen WSW according to the recommendations for females of their age and risk factor status.

Men Who Have Sex with Men (MSM). Screen MSM at least annually for urethral infection (if engaged in insertive anal intercourse during the preceding year, regardless of condom use) and/or rectal infection (if engaged in receptive anal intercourse during the preceding year, regardless of condom use). Screening for

pharyngeal infection is not recommended. MSM engaging in high-risk behaviors (e.g., anonymous partners, illicit drug use) or whose partners have other sexual partners should be screened every 3–6 months. Screen HIV-positive MSM when they enter the health care system and then at least annually at all relevant anatomic sites.

Males. Screen sexually active young men presenting in high-risk clinical settings (e.g., correctional facilities, STD or adolescent health clinics), living in high prevalence communities, or when resources permit and do not hinder chlamydia screening efforts in women.

Transgender individuals. Screen transgender individuals based on their current anatomy and sexual behaviors. Many transgender people have not had sex reassignment surgery and retain the genitals of their natal sex. They may engage in a range of sexual behaviors with men, women, or both.

2 Sequelae of Untreated Chlamydial Infection in Females

Estimated 2.8 million+ new infections each year



Pelvic inflammatory disease (PID) may develop in up to 15% of cases of untreated chlamydial infection

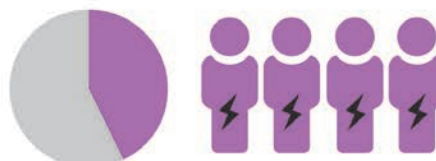


UNTREATED

Untreated PID may lead to:



Infertility
18%



Chronic pelvic pain
43%



Ectopic pregnancy
9%

Sources: Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance, 2014. Haggerty CL, et al. Risk of sequelae after *Chlamydia trachomatis* genital infection in women. *J Infect Dis.* 2010;201(Suppl 2):S124–S155. Trent M, et al. Recurrent PID, subsequent STI, and reproductive health outcomes: Findings from the PID Evaluation and Clinical Health (PEACH) study. *Sex Transm Dis.* 2011;38(9):879–881.

Taking a Sexual History

Screening for chlamydia starts with taking a patient's sexual history. A healthcare provider can collect this information as part of the patient's overall medical history or risk appraisal, or the patient can fill out forms in advance and a provider can review them.

TIPS FOR TAKING A SEXUAL HISTORY

- ▶ Establish rapport to make the patient feel comfortable.
- ▶ State that the discussion is confidential except if certain facts are revealed, such as if the patient discloses that he or she is a victim of abuse or is a danger to him or herself or someone else. Confidentiality is particularly important for adolescents, who are often reluctant to divulge sensitive information.
- ▶ Normalize the conversation by saying you ask all your patients about their sexual history because sexual health is an important aspect of overall health.
- ▶ Think in terms of the five **Ps**:
 - **Partners**
 - **Prevention of pregnancy/** Reproductive life plan
 - **Protection from STDs**
 - **Practices**
 - **Past history of STDs**
- ▶ Ask open-ended questions that are framed in a neutral, nonjudgmental manner.
- ▶ Do not make assumptions about a patient based on appearance, age, marital status, or any factor. In order to know a person's sexual behaviors, gender identity, or sexual orientation, you must first ask.
- ▶ Use everyday language and avoid clinical terms the patient may not understand.
- ▶ Be sure to allow the patient to ask questions. Likewise, ask the patient to explain any unfamiliar terms.

Suggested questions to ask are:

"Have you been sexually active in the past year?"

"Do you have sex with men, women, or both?"

"What kinds of sex are you having?"

"How many sexual partners have you had in the past year? Six months?"

"Do you know if your partner has other partners?"

"What do you do to protect yourself from sexually transmitted diseases?"

"Have you ever had a sexually transmitted disease?"

"Would you like to have (more) children?"

If no: "Are you doing anything to prevent pregnancy?" **If yes:** "When would you like to have a child?" "What are you and your partner doing to prevent pregnancy until that time?"

Additional questions you may want to ask include the following:

"Have you ever been coerced or pressured to have sex?" "Have you or your partners used alcohol or drugs when you had sex?" "Have you ever been incarcerated?"

SPECIAL CONSIDERATIONS FOR TEENS

Broaching sensitive subjects like sexual behavior can be difficult for providers and teens. However, providers play an important role in identifying risk behaviors and educating adolescents about ways to reduce their sexual risk. It can take time to establish a rapport with your teen patients, but it is worth the effort.

You can incorporate taking a sexual history into a well or acute care visit, or when the teen presents for a sports, school, or camp physical. Always administer the sexual history in private without a parent present. Explain to parents that you spend a portion of each visit alone with your adolescent patients. This helps parents understand this is standard procedure and is not specific to their child.

The sexual history should be part of a broader psychosocial assessment. Adolescent health experts recommend the HEEADSSS interview tool. The interview covers the topics of Home, Education (or employment), Eating, Activities, Drugs, Sexuality, Suicide/depression, and Safety. For more information about the HEEADSSS interview, see [Resource 2](#).

Office policies are useful for standardizing procedures. Consider developing an office policy that includes:

- ▶ the age at which sexual history taking begins (the American Medical Association and American Academy of Pediatrics recommend starting at age 11)
- ▶ a plan that outlines how and when the sexual history will be taken, how parents are informed about the need for time alone with the adolescent, where results will be discussed and by whom, and how results will be confidentially documented
- ▶ how the information collected is integrated into overall adolescent care
- ▶ how staff will be trained to take sexual histories of adolescent patients

SEXUAL HISTORY RESOURCES

Adolescent Health Working Group – Sexual Health: An Adolescent Provider Toolkit ([Resource 3](#))

American Academy of Family Physicians – The Proactive Sexual Health History ([Resource 4](#))

Cardea – Sexual History-Taking Toolkit ([Resource 5](#))

Centers for Disease Control and Prevention – A Guide to Taking a Sexual History ([Resource 6](#))

National Association of Community Health Centers – Taking Routine Histories of Sexual Health: A System-Wide Approach for Health Centers ([Resource 7](#))

Testing for Chlamydial Infection

NAATs (Nucleic acid amplified tests) are recommended for detecting chlamydia bacteria. Urine, vaginal, endocervical, urethral, and rectal specimens can be tested. Urine testing is convenient and appropriate for many settings, especially those where pelvic exams are not routinely conducted. See the CDC's report *Recommendations for the Laboratory-Based Detection of Chlamydia trachomatis and Neisseria gonorrhea – 2014* for more information on testing ([Resource 8](#)).

- ▶ NAATs are FDA-cleared for urine, urethral, vaginal, and endocervical specimens. They are not FDA-cleared for rectal specimens, but many laboratories have validated NAATs for such use. Most NAATs are FDA-cleared for dual testing of chlamydia and gonorrhea in vaginal and endocervical specimens from women, urethral specimens from men, and urine specimens from both men and women.
- ▶ A clinician- or self-collected vaginal swab is recommended for females (the self-collection of vaginal swabs is FDA-cleared for clinical settings). Endocervical swabs and urine are other acceptable specimens. Urine is recommended for males. NAATs are most sensitive when used with a first-catch urine sample.

- ▶ Non-NAAT tests, such as DNA probe, direct fluorescent antibody test (DFA), and enzyme immunoassays (EIA), are not recommended. These tests are less sensitive than NAATs and thus miss a larger number of infections.
- ▶ Contact your laboratory for detailed information on tests and procedures for handling specimens.

SIGNS AND SYMPTOMS OF INFECTION

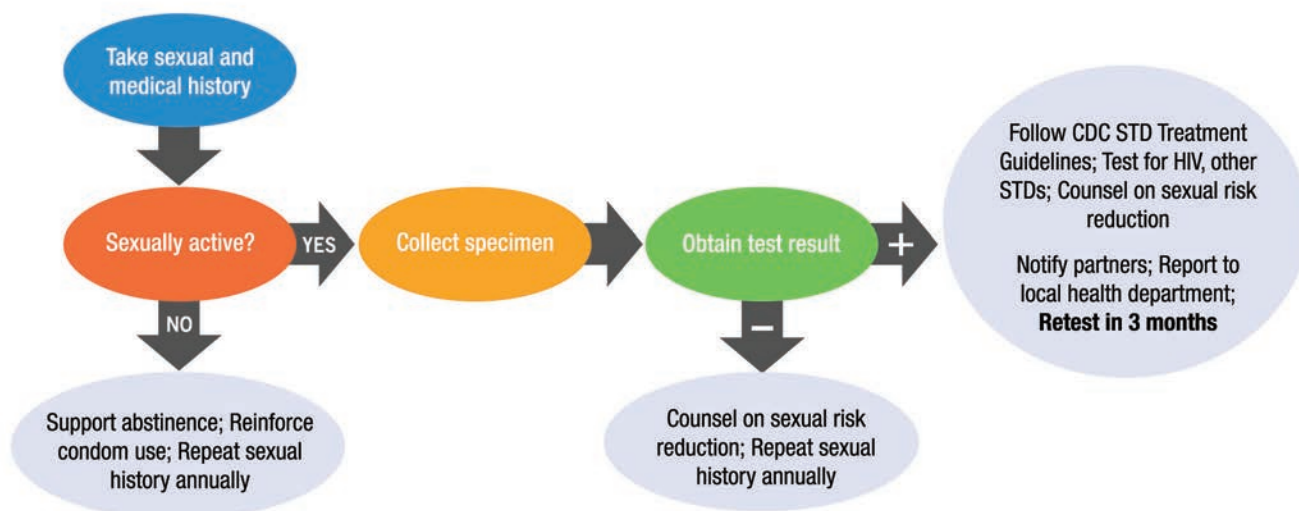
Although most people with chlamydial infection have no symptoms, the following should prompt diagnostic testing:

- ▶ Dysuria (males and females)
- ▶ Abnormal vaginal discharge

- ▶ Vaginitis
- ▶ Cervicitis
- ▶ Post-coital bleeding
- ▶ Intermenstrual bleeding
- ▶ Painful intercourse
- ▶ PID symptoms, such as abdominal pain, low back pain, fever
- ▶ Penile itching, burning, or discharge
- ▶ Rectal pain, discharge, or bleeding (males and females)

3 Age-based Screening Pathway

Asymptomatic female, 24 years and younger



COMMUNICATING TEST RESULTS

Develop a standard protocol for confidentially communicating test results to patients, if one is not already in place. Within this protocol, specify which test results (normal only, or both abnormal and normal) are communicated, the timeframe within which those results are communicated, the office staff responsible, and the method by which different results

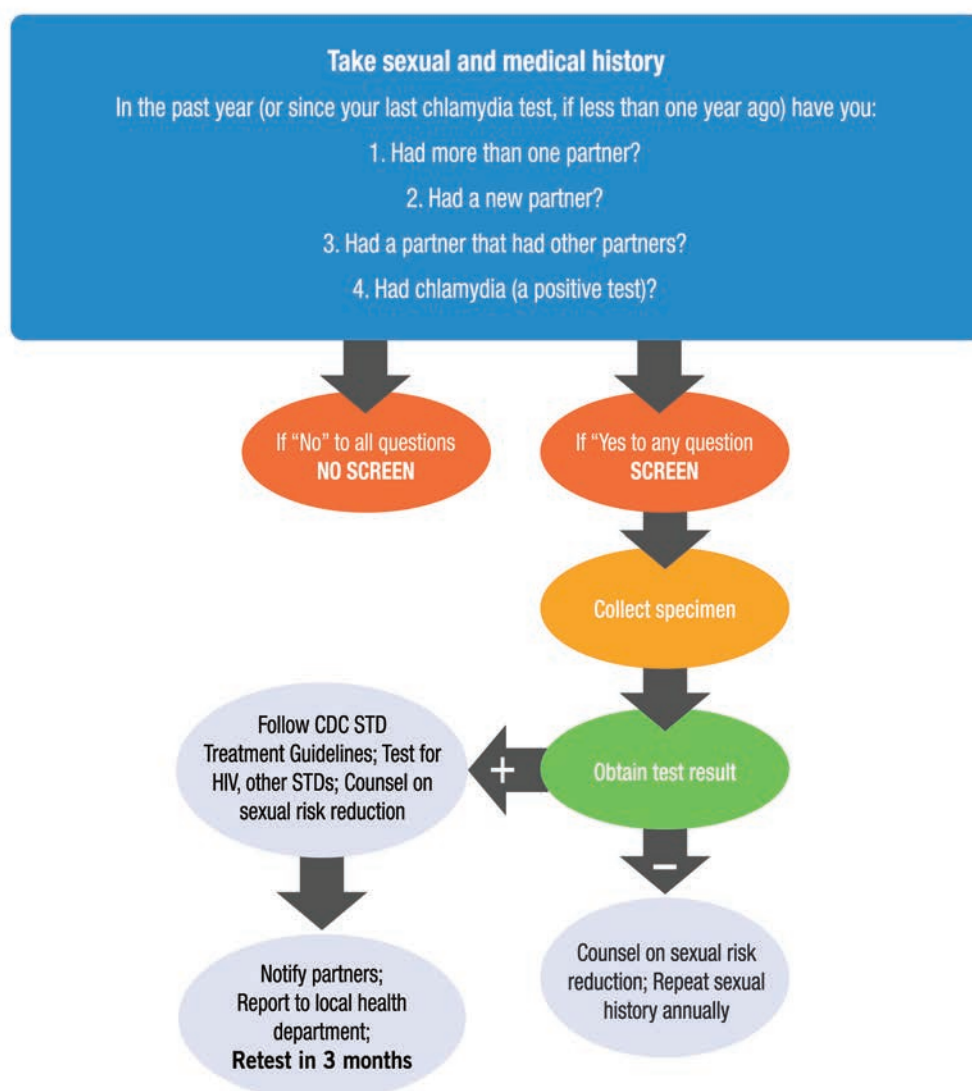
are communicated. Once this protocol is established, inform all your patients about how and when they will be notified of their test result. Lastly, be sure to document the notification in your electronic health record (EHR).

Research shows that most patients prefer to be notified about both abnormal and abnormal results. Many offices use a secure online portal that allows patients

to confidentially access their test results and other health information. Normal test results can also be sent through the mail. Abnormal results are often confidentially communicated by phone or in a follow-up visit. Communicating a chlamydia test result to an adolescent can be slightly more challenging than for an adult. Ask adolescents how they would like to be contacted to receive their result.

4 Risk-based Screening Pathway

Asymptomatic female, 25 years and older



Treating Chlamydial Infection

Treatment should begin immediately after diagnosis to prevent complications and further transmission. Complete information about treatment regimens is found in the CDC's *Sexually Transmitted Diseases Treatment Guidelines, 2015* ([Resource 9](#)).

Instruct all patients with chlamydial infection to abstain from sexual intercourse for 7 days after taking a single-dose treatment or until completing a 7-day treatment. They should also abstain until all sex partners have completed treatment.

RECOMMENDED REGIMENS FOR NON-PREGNANT FEMALES AND MALES

*Azithromycin 1 g orally in
a single dose*

— OR —

*Doxycycline 100 mg orally
twice a day for 7 days*

Azithromycin and doxycycline are equally effective at treating urogenital chlamydial infections. A single dose of azithromycin should be available onsite and directly observed among patients for whom a multi-day course of treatment may be problematic. A test-of-cure is not recommended unless compliance with treatment is questionable, symptoms persist, or infection reoccurs. Repeating testing less than 3 weeks after completing treatment may result in false positives.

ALTERNATIVE REGIMENS FOR NON-PREGNANT FEMALES AND MALES

*Erythromycin base 500 mg orally
4 times a day for 7 days*
— OR —

*Erythromycin ethylsuccinate 800 mg orally
4 times a day for 7 days*
— OR —

*Levofloxacin 500 mg orally
once daily for 7 days*
— OR —

*Ofloxacin 300 mg orally
twice a day for 7 days*

Erythromycin causes greater gastrointestinal side effects than azithromycin or doxycycline and therefore may be less efficacious. Levofloxacin and ofloxacin are more expensive than azithromycin and doxycycline, and still require a 7-day course of treatment so these medications confer no advantage over the recommended treatments.

RECOMMENDED REGIMEN FOR PREGNANT FEMALES

*Azithromycin 1 g orally in
a single dose*

Doxycycline is contraindicated during the second and third trimesters, and ofloxacin and levofloxacin are Category C drugs, which means there is a potential risk to the fetus. Therefore, only azithromycin is recommended for pregnant women. Perform a test-of-cure 3-4 weeks after completing treatment to ensure the infection has been eradicated. Retest all pregnant women who have chlamydial infection 3 months after completing treatment.

ALTERNATIVE REGIMENS FOR PREGNANT FEMALES

*Amoxicillin 500 mg orally
3 times a day for 7 days*
— OR —

*Erythromycin base 500 mg orally
4 times a day for 7 days*
— OR —

*Erythromycin base 250 mg orally
4 times a day for 14 days*
— OR —

*Erythromycin ethylsuccinate 800 mg orally
4 times a day for 7 days*
— OR —

*Erythromycin ethylsuccinate 400 mg orally
4 times a day for 14 days*

Amoxicillin is now considered an alternative therapy for pregnant women. Erythromycin's frequent gastrointestinal side effects can create issues with adherence. The lower-dose 14-day regimen can be prescribed if gastrointestinal side effects are a concern.

RETESTING AFTER TREATMENT

CDC recommends that all males and females be retested 3 months after completing treatment. Alternatively, patients can be retested opportunistically when they next present for medical care within 12 months of the initial treatment.

Reinfection after treatment is common, particularly among adolescents. Reinfection typically occurs because all sex partners were not treated or the patient has a new partner who is infected. Treatment failure is a less common reason for reinfection. Preventing reinfection in females is important because each subsequent chlamydial infection increases the risk for PID and ectopic pregnancy.

Consider implementing practice- and patient-level interventions to increase your office's retesting rates. When counseling patients, emphasize the need to return for retesting and help them to remember their retesting appointment, such as through a reminder card or mailed postcard. Revise patient education materials to include information about reinfection and retesting. To reduce missed opportunities, establish reminders or prompts for retesting, develop a policy that prioritizes retesting, and take a sexual history at every visit to assess STD history in the past year.

Notifying and Managing Partners

Sexual partners of a patient with diagnosed chlamydial infection should be notified to seek health care for testing and treatment. The patient, a member of your medical team, or a trained health department employee can notify partners.

- ▶ Check with your local health department to see if partner notification services are available for chlamydial infection. Even health departments with limited resources may prioritize certain patients for partner notification services, such as pregnant females, patients co-infected with HIV, those with recurring chlamydial infection, patients engaging in high-risk behaviors, and those concerned about the possibility of physical violence.
- ▶ Inform your patients that if their sexual partner(s) is (are) not treated, they will very likely be infected again. Explain that an untreated infection can spread to others and can cause health complications. Educate your female patients about the increased risk of pelvic inflammatory disease and ectopic pregnancies from repeat chlamydial infections.
- ▶ Ask your patients how they would like to notify partners. Most prefer to notify their partners in-person or by phone. You can help them to do so by suggesting they find a quiet time and place where they can talk privately with their partner, and to be straightforward that they have chlamydia. They should be ready for a range of reactions. If a patient is fearful that a partner will react violently or qualifies as a case your local health department would provide partner services to, encourage him or her to work with the health department to notify partners.
- ▶ Email and text messages are other options. [InSPOT.org](https://www.inSPOT.org) is a free online service that sends anonymous e-cards to notify partners to get tested. [Dontspreadit.com](https://www.dontspreadit.com) sends anonymous emails or text messages to alert partners that they may have been exposed to a sexually transmitted disease. [Sotheycanknow.org](https://www.sotheycanknow.org) also offers anonymous e-cards and emails, as well as tips for telling a partner in-person.

Questions you might ask your patients are:

"How would you like to let your partner(s) know that he/she needs to be tested for chlamydia?"

"How do you think your partner will react?"

"How are you feeling? Some people feel embarrassed or angry when they're diagnosed with an STD."

Remind patients who choose to notify partners themselves to share these key points with their partner:

"You have been exposed to chlamydia and could be infected."

"You should get tested and treated as soon as possible."

"If you are infected with chlamydia too, avoid having sex for 7 days after you begin treatment."

EXPEDITED PARTNER THERAPY

When a partner exposed to chlamydia in the past 60 days is unable or unlikely to seek medical care, expedited partner therapy (EPT) is warranted. EPT is the practice of treating a sexual partner without that person being clinically assessed. It is supported by CDC, the American College of Obstetricians and Gynecologists (ACOG), the American Medical Association (AMA), the American Academy of Pediatrics (AAP), and the Society for Adolescent Health and Medicine (SAHM). EPT is recommended for treating the sexual partners of heterosexual men and women, but is not routinely recommended for partners of MSM. MSM have a higher risk for undiagnosed co-infections, particularly HIV. EPT is also not recommended in cases of suspected child abuse, sexual assault or abuse, or in cases where the patient's safety is questionable.

Most states allow EPT and it is possibly permissible in several others. You can find the legal status of EPT in your state at [Resource 10](#). If your state allows EPT, find out the terms under which you must operate, who within your practice can provide EPT, and any liabilities. See if your state health department has guidelines to help you overcome challenges to implementing EPT, which can include potential drug allergies, operational issues related to EHRs (such as not having identifying information to link to a prescription) or liability concerns.

Patient-delivered partner therapy (PDPT) is the most commonly used form of EPT. With PDPT, the patient gives the sex partner a prescription or medication along with educational materials and instructions for taking the medication. The partner is also urged to seek medical care. This is particularly important for female partners because of the risk of pelvic inflammatory disease (PID).

REPORTING TO THE HEALTH DEPARTMENT

Every state mandates physicians or other healthcare providers, medical facilities, and/or laboratories to report cases of chlamydia to the health department. Check with your state health department for specific reporting requirements. Reporting does not conflict with HIPAA because the law permits sharing protected health information for specified public health purposes.

Your local health department can answer questions about how and when to report, and whether to report laboratory-confirmed or suspected cases of chlamydia. You can find your nearest health department at [Resource 11](#).

Providing Services to Adolescents

Adolescents often need sexual and reproductive health services. However, the healthcare system can make it difficult for them to get needed care. Many adolescents are very concerned about confidentiality and may forgo being tested for an STD out of worry that their parents will find out. Other barriers to teens seeking care include the following:

- ▶ limited ability to pay for services or medications
- ▶ previous negative experiences with the healthcare system
- ▶ a lack of transportation to get to appointments
- ▶ unfamiliarity with the healthcare system
- ▶ offices having inconvenient hours

With some time and effort, you can address many of these barriers to create a more welcoming environment for adolescents.

CONSENT TO SERVICES

Minors under the age of 18 can consent to receive STD services, including chlamydia screening and diagnostic testing, in all 50 states and the District of Columbia. Some states require that the minor be of a certain age (usually 12 or 14 years). See [Resource 12](#) for a summary of state minor consent laws.

CONFIDENTIALITY OF SERVICES

Confidentiality is of the utmost importance to many teens. The medical information of a minor who has consented to receive STD services is protected by a variety of laws. Although you strive to protect your patients' confidential information, there are circumstances when you may need to breach that trust. Some states allow providers the option of notifying parents that a teen has received STD care. Providers are also required by state law to report suspected cases of physical or sexual abuse or neglect.

The insurance claims process often breaches the confidentiality of adolescents, young adults, and other adult dependents covered under someone else's insurance policy. Commercial health plans typically inform policyholders when a claim was made for someone covered under their policy. This Explanation of Benefits (EOB) is intended to prevent fraud and identity theft, but virtually eliminates an adolescent's ability to seek care as an insured dependent without parental knowledge. A few states, including California and Oregon, allow minors to request that the health insurer send the EOB to another address.

Sending the adolescent's family a bill for a copay may also breach confidentiality. Under HIPAA, patients, including adolescents, are allowed to request that communications about their personal health information be sent to another address or location, and providers must accommodate reasonable requests.

In addition to the insurance claims process, EHRs and associated online portals can also breach adolescents' confidentiality. To protect the confidentiality of adolescents and comply with state laws, offices may restrict parental access to the adolescent's patient portal starting at a given age (often 12 or 13). Although this practice does protect the adolescent's private health information, parents still play an important role in facilitating their teen's transition to assuming responsibility for their healthcare. Completely eliminating access to their child's EHR can make it more difficult to play that supportive role. EHRs can be modified to allow for shared use by both parents and teens, but with each having different access to health information.

Strategies to help ensure your adolescents' confidentiality include the following:

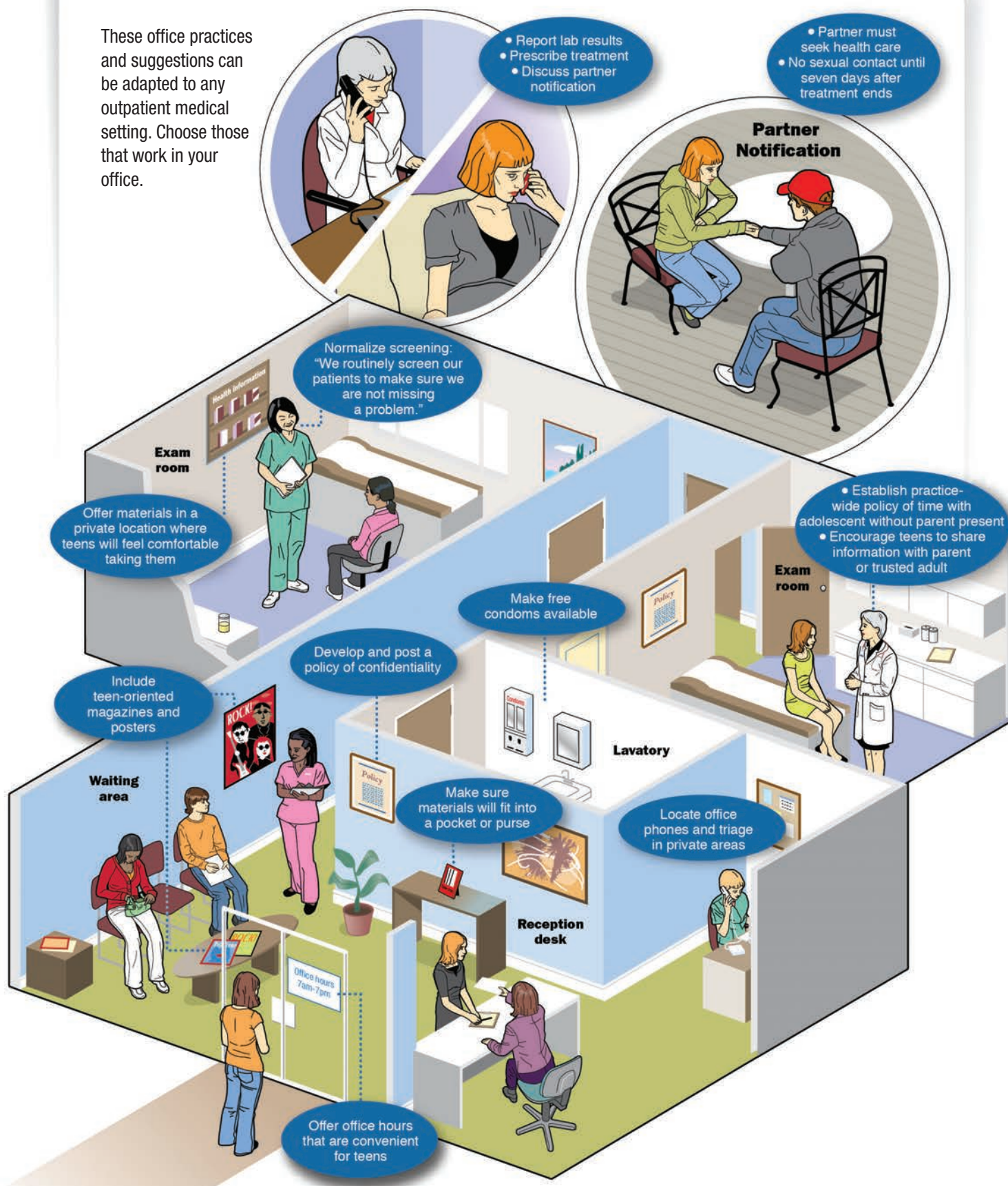
- ▶ Set restrictions on which health information is available through the patient portal. You could consider allowing adolescents to have full access to all their health information, but restrict parental access. This option may require customizing your EHR.
- ▶ Establish a policy that your office will not discuss or release sensitive health information to parents without the adolescent's permission.
- ▶ Educate teen patients that they can request communications from your office be sent to a different address or location.
- ▶ Offer the teens the option of paying out-of-pocket, perhaps at a reduced cost. Check with your insurer' terms of agreement to see if this is permitted.
- ▶ Encourage teens to communicate with their parents about sensitive health topics, such as screenings for STDs. This minimizes the need for teens to withhold information.
- ▶ Refer patients to Title X-funded clinics, which do not send EOBs. This should be a last resort only if you are unable to implement any of the above strategies. See [Resource 13](#) to find a free testing location.

ADOLESCENT HEALTHCARE RESOURCES

- ▶ Adolescent Health Working Group – Adolescent Health Care 101: Provider Toolkit ([Resource 14](#))
- ▶ American Academy of Pediatrics – Adolescent Health ([Resource 15](#))
- ▶ Society of Adolescent Health and Medicine – Adolescent and Young Adult Clinical Care Resources ([Resource 16](#))

5 Teen Friendly Office Tips

These office practices and suggestions can be adapted to any outpatient medical setting. Choose those that work in your office.



Putting Screening into Practice

Simple changes to your office procedures can increase how often you screen patients for chlamydia, and ensure that you are not missing opportunities to retest.

PRIORITIZE STDs AND SCREENING

- Designate someone in your office to lead your effort to increase chlamydia screening. Leadership is necessary to ensure changes are made that will boost your screening rate.
- Make sure your office staff understands that chlamydial infection is serious and prioritizes suspected cases. Staff members should know the screening recommendations for different patient populations.

DETERMINE AN APPROPRIATE SCREENING METHOD

- Choose which specimen to collect to screen your patients. Vaginal specimens, either patient- or clinician-obtained, are preferred for screening asymptomatic females. Urine may also be obtained for both males and females. Patients prefer self-collected vaginal swab- or urine-based screening because it is less invasive than collecting an endocervical or urethral swab specimen. Adolescent females are particularly good candidates for self-collected vaginal swab or urine-based screening because they do not need pelvic exams if they are asymptomatic.
- Collect a swab sample if a pelvic exam is indicated, if testing for rectal infection, or if urine-based or self-collected vaginal swab screening is infeasible. One cervical specimen can test for both cervical cancer and chlamydia. When a Pap test is not indicated, female patients can also self-collect a vaginal specimen.

DEVELOP AND IMPLEMENT PRACTICE SYSTEMS

- Take every patient's sexual history. This normalizes discussing sexual behavior and allows providers to identify issues that jeopardize a patient's sexual health. For adolescents, take a sexual history at every visit, not only well visits.
- Systematize the collection of a specimen from patients. If implementing urine-based screening, consider asking all your adolescent and young adult patients to leave a urine sample before entering the exam room. Test only the specimens of those patients identified during the sexual history as being sexually active or due for screening. Post instructions on how patients should properly collect a vaginal or urine sample to avoid contamination.
- Use protocols, office policies, standing orders, and reminder systems to streamline your practice's procedures. By outlining who is responsible for certain tasks, and how and when to do those tasks, you can help to ensure that opportunities for screening or retesting are not missed.
- Establish a reminder system in your EHR to notify patients when they are due to be screened or retested. If your practice does not have an EHR, alternatives include postcards, emails, or text messages to remind patients. This system can also alert healthcare providers when a patient is due or overdue to be screened or retested. Develop policies for taking a sexual history, confidentiality, and time alone with adolescent patients, and be sure that all staff know and follow these policies.

EDUCATE PROVIDERS AND PATIENTS ABOUT CHLAMYDIA AND OTHER STDs

- Promote continuing education courses to the providers in your practice. See [Resource 17](#) for a list of online continuing education resources related to STDs.
- Provide patient education materials about STDs and sexual health in your waiting room and in each exam room. See [Resource 18](#) for an example. You could also direct patients to reputable web sites with consumer-oriented information about sexual health and STDs, such as Medline Plus, Mayo Clinic, CDC, Planned Parenthood, and American Sexual Health Association.
- Contact your state or local health department for training opportunities or resources. Also, medical associations may offer continuing education opportunities related to STDs and sexual health.

Resources

Resource 1: U.S. Preventive Services Task Force. Screening for Chlamydia and Gonorrhea.
<http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/chlamydia-and-gonorrhea-screening>

Resource 2: Contemporary Pediatrics. HEEADSSS 3.0.
<http://contemporarypediatrics.modernmedicine.com/contemporary-pediatrics/content/tags/adolescent-medicine/heeadsss-30-psychosocial-interview-adolesce?page=full>

Resource 3: Adolescent Health Working Group. Sexual Health: An Adolescent Provider Toolkit.
http://ahwg.net/uploads/3/4/5/5/34557719/sexual_health_toolkit_2010_final.pdf

Resource 4: American Academy of Family Physicians. The Proactive Sexual Health History.
<http://www.aafp.org/afp/2002/1101/p1705.html>

Resource 5: Cardea. Sexual History-Taking Toolkit.
<http://www.cardeaservices.org/resourcecenter/sexual-history-taking-toolkit>

Resource 6: Centers for Disease Control and Prevention. A Guide to Taking a Sexual History.
<https://www.cdc.gov/std/treatment/sexualhistory.pdf>

Resource 7: National Association of Community Health Centers. Taking Routine Histories of Sexual Health: A System-Wide Approach for Health Centers.
http://nachc.org/wp-content/uploads/2015/06/Taking-Routine-Histories-of-Sexual-Health-Toolkit_Dec-2015.pdf

Resource 8: Centers for Disease Control and Prevention. Recommendations for the Laboratory-Based Detection of Chlamydia trachomatis and Neisseria gonorrhea – 2014.
<http://www.cdc.gov/std/laboratory/2014labrec/2014-lab-rec.pdf>

Resource 9: Centers for Disease Control and Prevention. Sexually Transmitted Disease Treatment Guidelines, 2015.
<http://www.cdc.gov/std/tg2015/>

Resource 10: Centers for Disease Control and Prevention. Legal Status of Expedited Partner Therapy (EPT).
<http://www.cdc.gov/std/ept/legal/default.htm>

Resource 11: National Association of County and City Health Officials. Directory of Local Health Departments.
<http://www.naccho.org/resources/lhd-directory>

Resource 12: Guttmacher Institute. State Minor Consent Laws.
<https://www.guttmacher.org/state-policy/explore/minors-access-sti-services>

Resource 13: Centers for Disease Control and Prevention. Get Tested.
<https://gettested.cdc.gov/>

Resource 14: Adolescent Health Working Group. Adolescent Health Care 101: The Basics – CA Edition.
http://ahwg.net/uploads/3/4/5/5/34557719/adolescent_health_care_101.pdf

Resource 15: American Academy of Pediatrics. Adolescent Health.
<http://www2.aap.org/sections/adolescenthealth/>

Resource 16: Society for Adolescent Health and Medicine. Adolescent and Young Adult Clinical Care Resources.
<https://www.adolescenthealth.org/Clinical-Care-Resources/Adolescent-and-Young-Adult-Resource-Guides.aspx>

Resource 17: Centers for Disease Control and Prevention. Continuing Education Online.
<http://www.cdc.gov/std/training/onlinetraining.htm>

Resource 18: National Coalition for Sexual Health. Public Awareness Materials.
<http://nationalcoalitionforsexualhealth.org/tools/communicating-to-the-public/public-awareness-materials>

Additional Information about STDs and Sexual Health

American Sexual Health Association
<http://www.ashastd.org>

Centers for Disease Control and Prevention
<http://www.cdc.gov/std>

Get Yourself Tested
<http://www.itsyoursexlife.com/gyt/>

National HIV and STD Testing Resources
<http://hivtest.cdc.gov/STDTesting.aspx>

Mayo Clinic
<http://www.mayoclinic.org>

Medline Plus
<http://www.nlm.nih.gov/medlineplus/sexuallytransmitteddiseases.html>

Planned Parenthood
<http://www.plannedparenthood.org>

