Infertility Prevention Project

Regional Epidemiologic Profile of Pregnancy-Testing Only Clients

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TABLE OF CONTENTS **Page**

APPENDIX

Special Project Report

Identifying Missed Opportunities for Chlamydia Screening Among Young, At-Risk Females

A. Background

The Centers for Disease Control and Prevention (CDC) recommends annual screening of all sexually active women 25 years of age or younger for chlamydia. In order to assess chlamydia screening coverage among females attending Title X family planning clinics, CDC devised a measure of effectiveness examining the proportion of unique female users screened for chlamydia by age group. This assessment draws upon readily available Family Planning Annual Report (FPAR) data reported by all Title X grantees to the Office of Population Affairs (OPA).

Since 2005 (the first year grantees were required to report specifically on the number of users that received a chlamydia test), screening coverage in family planning has slowly increased among the most at-risk females aged 15-24 years. According to Region II prevalence monitoring data for the year 2010, the median state-specific chlamydia positivity among these users was high, at 7.0%. In Region II, from CY2005 to CY2010, screening coverage in Title X facilities increased from 45% to 56% among females aged 15-19 and from 48% to 61% among females aged 20-24 years. While these increases are noteworthy and consistent with national efforts to increase screening coverage for younger females, roughly 40% of females in the target population still do not get screened as they should.

In order to increase the proportion of young females aged ≤26 years screened for chlamydia, programs should consider missed opportunities for screening at-risk young women. Chlamydia testing is often performed as part of a pelvic exam. However, the provision of family planning services has changed over time. Specifically, many family planning clinics offer "streamlined" services to young women that do not require a pelvic exam, including pregnancy testing, emergency contraception, and HIV testing. It is important to understand which clients receive a chlamydia test and which do not, the characteristics of these clients (especially age), clinic protocols, and the circumstances under which chlamydia testing is offered in order to explore opportunities to close gaps in screening coverage.

Several pilot studies conducted across the nation have shown that family planning users requesting walk-in pregnancy test only (PTO) services represent a group of young sexually active women at high risk of chlamydial infection.[1] Using NAAT (nucleic acid amplification test) technology, providers can offer urine-based chlamydia screening during PTO visits as

[1] Chlamydia Positivity among Women coming into Title X Family Planning Clinics for Pregnancy Testing Only: A summary of demonstration projects conducted in Regional Infertility Prevention Projects, 1997-2005. Linda Dicker (CDC), Dawn Middleton (Region III), Adelbert James (Region IV), Karla Johnson (Region VII), Pat Blackburn (Region IX), Debra Mosure (CDC), Dorothy Gunter (CDC).

an opportunity to increase the identification of currently undiagnosed chlamydial infection within a clinic population.

B. Methods and Data Collection

From 2008-2010, each of the ten Regional Infertility Prevention Projects (IPP) conducted an assessment to better understand characteristics of family planning users that are not getting a chlamydia test, and what types of services these users are receiving. This process was used to help programs identify and pilot strategies for expanding and monitoring screening to the most at-risk populations.
In July 2009, a data collection tool was designed that included four components:

1. Estimated chlamydia screening coverage by age group, race, and ethnicity
2. Family Planning Services Provided to Unique Female Users by Age Group
3. Proportion of Female Family Planning Users Tested for Chlamydia by Visit Type or Services Provide
4. Chlamydia Positivity among Female Family Planning Users Tested for Chlamydia, by Visit Type and Age Group

A copy of this data collection tool is provided in the Appendix

C. Results

All Title X grantees were asked to provide the data requested, using available administrative data systems, laboratory reports, or electronic medical records. However, only one grantee – Public Health Solutions in New York City, and its three delegates (MIC, The Door, and Planned Parenthood NYC) – was able to provide the requested data. Challenges in reporting data by the other project areas included the following:

- Data systems are unable to distinguish "pregnancy test only" clients; only "initial or annual visit" is standard
- Limited use of urine-based NAAT is some family planning settings meant screening was limited to initial or annual exam.
- Regional screening guidelines were previously limited to initial or annual exam.
- Lab data (test results and positivity) and administrative data (visit type) stored in different systems, making calculation of positivity by service/visit type a challenge.
- Unable to extract data as requested without engaging IT staff to develop custom reports.

A summary of the preliminary data collected for CY2008 were previously presented at the November 2009 Region II IPP Meeting; slides are available online: (http://www.cicatelli.org/ipp/Meetings/200911/PTOassessmentoverview11102009.pdf)

Additional data were submitted by each of the Public Health Solutions delegates for CY2009 and CY2010. Highlights are summarized below:

- MIC clinics increased NAAT utilization from CY2008 to CY2011, and implemented opt-out chlamydia screening for walk-in pregnancy testers; these changes are reflected in the data. Among 15-19 year olds in CY2010, the proportion of visits for pregnancy testing increased from 48% to 63% of all visits, while the proportion of visits for initial or annual exam decreased from 50% to 37%. Screening coverage was higher for initial or annual exam (>70%) but increased over time for pregnancy test visits from 27% in CY2008 to 34% in CY2010 (with a dip down to 18% in CY2009). Chlamydia positivity for pregnancy testers was nearly double that for other visit types by age group; however, this may reflect differences in test sensitivity since NAATs were only used for urine screening.

- Screening coverage at The Door Adolescent Clinic was over 90% for all clients. Pregnancy test only users represented <10% of clients; screening coverage for these clients varied by year, ranging from 56% in CY2009 to 91% in CY2010 for 15-19 year old females. Chlamydia positivity was considerably lower (approximately half as high) for pregnancy testers than clients with other visit types, although still >11%. The small number of pregnancy test only users, and lower positivity in this group, suggests that The Door is very effective in ensuring that high-risk adolescent clients return for an initial or annual exam.

- Data for Planned Parenthood New York City (PPNYC) were difficult to interpret due to inconsistencies in the way data were reported before and after the implementation of a new electronic medical record system. Still, trends suggest that screening coverage for initial or annual exams remained very high (>90%), while overall screening coverage for all visit types declined significantly between CY2008 and CY2010, from 65% to 40% for females aged 15-19 years and 77% to 47% for females aged 20-24 years. Positivity for pregnancy testers was comparable to or slightly higher than positivity for other visits.

D. Implications and Follow-Up

The data provided by these three Title X delegate sites in New York City underscore some important lessons about performance management. First, even when programs have the systems in place needed to extract and analyze screening coverage and positivity for different service/visit types, data quality may be an issue. Specifically, how you define a visit type must remain consistent over time in order to interpret trends. Secondly, in order for

these data to be useful for continuous quality improvement, they must be analyzed locally and more often than annually. Programs that make adjustments to screening protocols in order to increase screening coverage would need to see this data on a monthly – possibly weekly basis in order to determine whether protocols were having an impact in the short term, and make adjustments as needed. Thus, having the capacity to report data does not automatically translate to using data to inform program.

Because most Title X grantees were unable to respond to the original data request, we conducted a follow-up assessment in November 2011 to determine whether programs had revised screening protocols or data systems to improve screening coverage among female family planning clients aged 15-24 years. Responses were received from five of the seven Title X grantees; Profamilia and the US Virgin Islands did not respond. See **Tables A and B** below.

Table A. Chlamydia Screening Criteria for Females in Family Planning, Region II Title X Family Planning Grantees†, November 2011

Screen all female FP clients aged 15-25 years for chlamydia...	**NJ DHSS**	**NJFPL**	**NYC**	**NYS**	**UPR**
At their initial or annual exam	X	X	X	X	X
When they visit the clinic for a pregnancy test	X	X	X		
When they visit the clinic for emergency contraception	X		X*		
When they visit the clinic for an HIV test	X	X			X
Each time they visit the clinic, regardless of the reason	X^				

^For females 20-25 years only; * For The Door Adolescent Health Center only

Table B. Chlamydia Screening Criteria for Females in Family Planning, Region II Title X Family Planning Grantees†, November 2011

Proportion of unduplicated users that were tested for chlamydia when they received a pregnancy test, HIV test, or emergency contraception.	**NJ DHSS**	**NJFPL**	**NYC**	**NYS**	**UPR**
Easy			X		X
Difficult		X			
Impossible					
Not Sure/No Response	X			X	

†NJDHSS = New Jersey Department of Health and Senior Services; NJFPL = New Jersey Family Planning League; NYC = Public Health Solutions; NYS = New York State Department of

Health Bureau of Women's Health; UPR = University of Puerto Rico Title X Family Planning Program.

Since the baseline assessment in July 2009, three of five grantees had implemented screening for pregnancy test visits; three of five for HIV test visits; and two of five for emergency contraception visits. Continued increases in overall estimated screening coverage should follow if these protocols are effective in expanding screening to at-risk populations that would have been missed if screening were limited to initial or annual visits. However, since pregnancy testers and emergency contraception visits account for a small proportion of visits in some settings, providers need to consider all missed opportunities. In particular, in some settings (e.g. PPNYC) "other" services accounted for nearly half of visits among females 15-19 and 20-24; the data seem to suggest that these users did not return for initial or annual exams. Defining these "other" visits is essential to addressing missed opportunities to screen.

Furthermore, only two programs report that extracting data for monitoring purposes is "easy" in 2011; others stated they had no plans to modify data systems to facilitate monitoring and reporting of screening coverage. Without accessible and easy to use data and reporting systems in place to monitor screening coverage at the local level, further improvement may be limited.