

# Region IV

## Infertility Prevention Project

Pregnancy-Test Only Clients (PTO)

Regional Epi Profile

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Special Report

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APPENDIX 1: PTO DATA COLLECTION TOOL

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**Special Report****A. BACKGROUND**

CDC recommends annual screening of all sexually active women aged  $\leq 25$  years 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 remained flat* among the most at-risk females in Region IV, at 52% among females aged 15-19 and ~54% among females aged 20-24 years. This means that nearly half of females in the target population do not get screened as they should. According to Region IV prevalence monitoring data for the year 2010, the median state-specific chlamydia positivity among these users was among the highest in the nation at 9.4%.

In order to increase the proportion of young females aged  $\leq 25$  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.<sup>1</sup> Using NAAT (nucleic acid amplification test) technology, providers can offer urine-based chlamydia screening during PTO visits as an opportunity to increase the identification of currently undiagnosed chlamydial infection within a clinic population.

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<sup>1</sup> 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).

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**Special Report****B. METHODS AND DATA COLLECTION**

As part of a nationally-coordinated effort from 2008-2010, the Region IV IPP Infrastructure engaged Title X family planning partners in a process to understand and describe differences in chlamydia screening coverage related to individual user characteristics and the types of services provided. This process was used to help programs identify and pilot strategies for expanding and monitoring screening to the most at-risk populations.

In August 2009, a data collection tool was developed and piloted, based on that developed by the Region II IPP and informed by discussion with the Region IV IPP Advisory Board. This tool 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 **Appendix 1**.

**C. RESULTS**

Data were collected in September and October 2009, and a breakout discussion was convened at the October 2009 regional AB meeting in Charleston, SC to review preliminary findings and discuss challenges.

As previously reported, all eight project areas in Region IV were able to submit some data. However, numerous challenges were evident and similar to those reported by other regions. Such challenges included the following:

- Title X data systems are older, and designed to support administrative functions and to report aggregate summary data for the FPAR; these systems are not generally designed to support client-level data analysis or custom reports.
- Data systems were not structured to facilitate client level analysis since some data elements (i.e. visit type) could not be captured or were collected in multiple systems that could not be readily linked

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- Data systems are unable to distinguish “pregnancy test only” clients; only “initial or annual visit” is standard
- Regional screening guidelines were previously limited to initial or annual exam.
- Unable to extract data as requested without engaging IT staff to develop custom reports.
- In some states, chlamydia screening was only conducted during initial or annual exams (e.g. Florida and most of North Carolina)

Only two states (Georgia and Tennessee) were able to report specifically on the number and proportion of pregnancy test only (PTO) users screened for chlamydia. In Georgia, 42% of PTO users were screened, versus 63% of users receiving an initial or annual exam (I/A). In Tennessee, the proportion of PTO users screened was actually higher than that for I/A exam users (54% versus 35%). The overall percent CT positivity in TN was 6.2% for PTO users versus 4.6% for I/A exam users; for users aged 15-19 years CT positivity was 9.2% vs. 7.0%, respectively for PTO and I/A exam users.

To address limitations in the use of readily available Title X administrative and laboratory data to analyze gaps in screening coverage associated with visit type in most states, the Region IV Infrastructure proposed for consideration an alternative methodology for collecting this data using a Room Study Tool, based on experience from national quality improvement efforts and experience of the Infrastructure. This would use in-clinic observation for limited periods of time to identify age-eligible females who were and were not screened, by visit type. However, this proposal was not supported by the regional Advisory Board.

**D. IMPLICATIONS AND FOLLOW UP**

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 seven of the eight project areas; Alabama did not respond. See tables below.

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**Chlamydia Screening Criteria for Females in Family Planning, Region IV Title X Family Planning Grantees (by State), November 2011**

<b>Screen all female FP clients aged 15-25 years for chlamydia...</b>	<b>FL</b>	<b>GA</b>	<b>KY</b>	<b>MS</b>	<b>NC</b>	<b>SC</b>	<b>TN</b>
At their initial or annual exam	X	X	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				X
When they visit the clinic for an HIV test							X
Each time they visit the clinic, regardless of the reason							

**Reported Difficulty of Extracting Data from Data System to Monitor and Evaluate Chlamydia Screening Coverage, Region IV Title X Family Planning Grantees (by State), November 2011**

<b>Proportion of unduplicated users that were tested for chlamydia when they received a pregnancy test, HIV test, or emergency contraception.</b>	<b>FL</b>	<b>GA</b>	<b>KY</b>	<b>MS</b>	<b>NC</b>	<b>SC</b>	<b>TN</b>
Easy			X				
Difficult	X			X			X
Impossible		X			X	X	
Not Sure/No Response							

Since the baseline assessment in July 2009, three of seven responding grantees had implemented screening for pregnancy test visits; three of seven for emergency contraception visits; and one of seven for HIV test 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 “other” services (e.g. in Mississippi) accounted for the majority of visits among females 15-19 and 20-24; since screening coverage during an initial or annual exam is high, but overall screening coverage is low, it would follow-up that many females who receive “other” services do not return for an initial

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or annual exam. Defining these “other” visits is essential to addressing missed opportunities to screen.

All programs in Region IV have used NAAT (nucleic acid amplification test) technology exclusively since 2002, which provides opportunities for screening with alternate specimen types (urine and vaginal swab). All but two project areas (Florida and Georgia) have begun offering vaginal swabs, with four project areas (Kentucky, Mississippi, North Carolina, and Tennessee) offering patient-collected vaginal swabs. All project areas offer urine as a specimen source except North Carolina, which has switched to vaginal swabs for all specimens. Georgia uses urine exclusively.

Six of the seven responding project areas indicated that it is “difficult” or “impossible” to extract data to monitor and evaluate the proportion of unduplicated users that were tested for chlamydia when they received a pregnancy test, HIV test, or emergency contraception; only one of these six (North Carolina) indicated that they have plans to modify their data systems to facilitate the collection of this data. One state, Kentucky, reported that extracting data in this manner is “easy” – owing in large part to the implementation over the last three years of a new and comprehensive laboratory reporting system and new protocols for capturing visit type. Although Alabama was unable to respond to this survey in time for this report, they have also been working to revise their data system to better reflect missed opportunities for chlamydia screening over the past three years. Despite some expanded screening criteria, without accessible and easy to use data and reporting systems in place to monitor screening coverage at the local level, opportunities for improving screening coverage may be limited.