

Region VIII Infertility Prevention Project~2009-2011 Strategic Plan  
PROGRAM MODEL

## **Vision**

The vision of the Region VIII Infertility Prevention Project in 3 year's time is:

The Region VIII Infertility Prevention Project is dedicated to the prevention of infertility caused by sexually transmitted diseases, particularly Chlamydia and gonorrhea.

## **Mission Statement**

The central purpose and role of the Region VIII Infertility Prevention Project is defined as:

The mission of the Region VIII Chlamydia Project is to assess and reduce the prevalence of Chlamydia and associated complications in family planning and STD clinic populations, and other community-based provider populations through a program of outreach, education, screening, treatment, and follow-up.

## **Project Values and Standards**

The values and standards governing the Region VIII Infertility Prevention Project's development will include the following:

In order to meet unmet and growing needs of the prevention and control of STD-related infertility, JSI will take a systematic approach to the continued implementation of the Region VIII IPP program structure. The JSI/Denver team, working with the Region VIII IPP program areas and CDC, will strive to be innovative in delivering high-quality services at low cost to the largest number of people. As we work toward strengthening local, state, and regional responses to STD and reproductive health challenges, JSI is committed to:

- Active participation of project beneficiaries in all activities
- Internal and external partnerships and collaborations
- Adopting a multi-sectoral approach to address the social and cultural factors that increase individual and community vulnerability, and
- Capacity-building to create or enhance sustainability.

Further, our efforts to build accessible, appropriate, effective, and efficient STD and reproductive service delivery programs in collaboration with partners will incorporate the following standards:

- **Appropriate Constellation of Services** —The cornerstone of an effective STD prevention and related services program is an appropriate mix of services from the public and private sectors, including community-based organizations (CBOs). It is this tailored constellation of integrated services that can be responsive to both physical and sociocultural environments. The range of offerings must address the rural-urban differential, gender, racial and economic inequity, and the needs of special populations such as adolescents, women, and other vulnerable groups. Community-based outreach programs complement clinic-based programs and bring services closer to community members. Social marketing of health products and services is also important to increase access to services.
- **Quality of Care**—To achieve high-quality services, two key dimensions of quality must be addressed: quality of fact and quality of perception. Quality of fact may involve upgrading provider skills and knowledge, implementing service standards and protocols, introducing a facilitative supervisory system and disseminating best practices. Underscoring all of this is a focus on client-oriented services, with providers trained to deal with equity issues around gender, economic status, residence, occupation, race, ethnicity, culture and language.
- **Equity**—Easy access to prevention and related services for people of all income groups, races, religions, genders, sexual orientation identities, and locations of residence can create equal opportunity for equal needs.
- **Efficiency**—Efficiency in the delivery of prevention and related services can be achieved by reducing cost without compromising access and quality through maximizing resource utilization, utilizing appropriate technologies, and improving staff capabilities. Improving efficiency may require institutional integration, which can be done without sacrificing the achievements made by some vertical programs.
- **Capacity Building**—The Region VIII IPP’s approach to service delivery management centers around building institutions from within. Specific activities include: increasing management capabilities through the introduction of management tools; training managers and clinical staff to use data for decision-making; and improving the capacity of programs in planning, management, and quality improvements.
- **Evaluation**—Service delivery programs must be evaluated periodically to identify achievements and gaps at the local, state, and regional levels. The participation of service providers and managers, with input from the community and clients, are critical. Issues of concern may be addressed through training, orientation, and policy intervention. Addressing some identified issues may require additional resources.

The Regional Plan is a tool for focusing regional efforts and communicating national priorities. It serves as a guide for work to be accomplished at the regional level and as a template for project areas in the development and maintenance of their local infertility prevention programs.

The Plan is organized by IPP Core Components and addresses the National IPP Priority Areas as described below.

**1. IPP Core Component: CLINICAL SERVICES**

**National IPP Priority Area:** Target/expand Chlamydia screening to young sexually active women and men at risk for infection in public and private settings.

**National IPP Priority Area:** Improve appropriate and timely treatment for persons diagnosed with chlamydial infection and their partners.

- Objectives should assure that adequate systems are in place to routinely monitor treatment timeliness and adequacy.

**2. IPP Core Component: DATA**

**National IPP Priority Area:** Incorporate analysis of regional prevalence monitoring data for regional and local data-directed program planning.

**3. IPP Core Component: LABORATORY**

**National IPP Priority Area:** Promote the use of high quality diagnostic tests for Chlamydia.

**4. IPP Core Component: TRAINING AND PROGRAM MANAGEMENT**

**National IPP Priority Area:** Increase adoption of “best practice” prevention strategies to reduce efficiency of Chlamydia transmission.

## **Overall Region VIII IPP Goals**

The Region VIII IPP’s goal is to support health care professionals in preventing STD-related infertility by promoting science and evidenced-based standards in the planning, implementation, and maintenance of targeted Chlamydia and gonorrhea screening programs throughout Region.

The following key targets will be achieved by the Region VIII Infertility Prevention Project over the next 3 years:

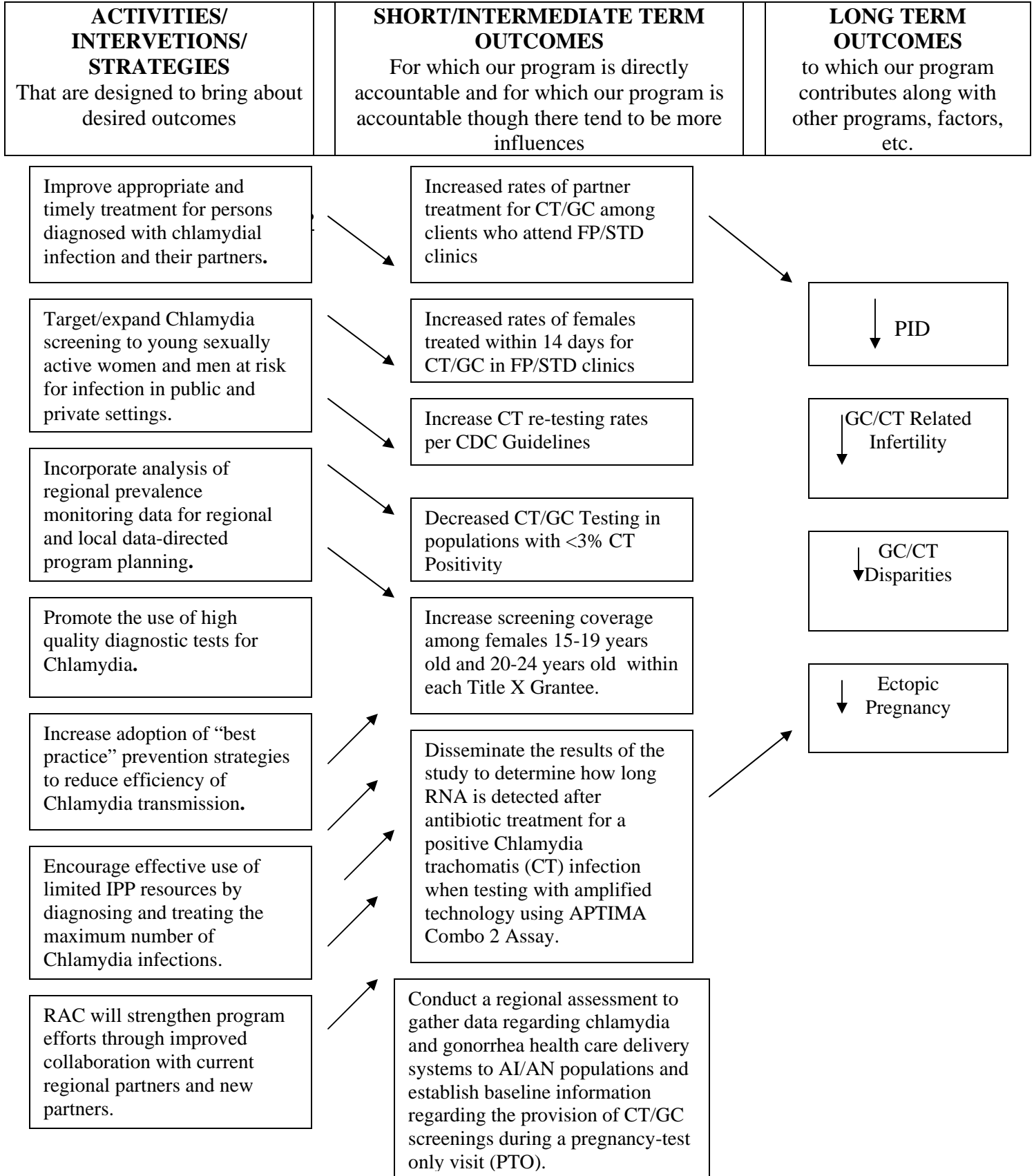
- Maintain a regional data collection system;
- Evaluate and update regional screening criteria;
- Expand services to facilities that reach high risk populations;
- Improve services, such as screening, treatment, and follow-up; and
- Reduce test, treatment, and laboratory costs.

## **Region VIII IPP Priority Areas**

Because STD and reproductive health programs exist in highly diverse, complex, and dynamic social health settings, the Region VIII IPP identified three primary components that are critical in order to implement a comprehensive program. These components are clinical services, lab services and data-informed programs. Each of these components has related priority areas. In support of CDC DSTDP's priority related to Chlamydia and gonorrhea prevention, "Prevention of STD-related Infertility and other complications of PID by screening and treating at-risk persons, primarily women <26 years of age, and by working to reduce racial/ethnic disparities in gonorrhea and Chlamydia", the RAC identified the following priority areas:

1. Determine and monitor screening coverage in Family Planning clinics conducting screening through the IPP.
2. Determine appropriate funding allocations for screening identified populations.
3. Assure availability of lower cost and quality lab technologies.
4. Ensure that Region VIII IPP Guidelines support best practices for the provision of partner services and primary prevention of CT/GC.
5. Target/expand Chlamydia screening to young sexually active women and men at risk for infection.
6. Adherence to screening criteria which includes that all women under 25 are screened; that all women over 25 are screened if they have a specific risk history or specific clinical symptoms, and establish a regional compliance rate.
7. Continue to support the collaboration between the Region VIII IPP and I.H.S. Stop Chlamydia Project.
8. Disseminate an evaluation of a standardized tool used to gather data regarding Chlamydia and gonorrhea health care delivery systems to AI/AN populations, as well as surveillance practices among AI/AN populations.
9. Disseminate a regional epidemiologic profile of pregnancy-testing only clients seen in prevalence monitoring clinics.
10. Establish baseline reinfection rates.
11. Define case-mix of screening population and establish a regional screening coverage goal.
12. Develop an IPP Health Communications Plan targeted towards providers, thereby increasing member knowledge and awareness of "Communications" best practices.
13. Assess and assure that adequate systems are in place to routinely monitor treatment timeliness and adequacy.
14. Promote the use of high quality diagnostic testing for Chlamydia and Gonorrhea through innovations in lab testing.

Region VIII Infertility Prevention Project PROGRAM MODEL



## **NATIONAL INFRASTRUCTURE PRIORITY ACTIVITIES SUMMARY**

- A. Development of a standardized tool used to gather data regarding Chlamydia and gonorrhea health care delivery systems to AI/AN populations, as well as surveillance practices among AI/AN populations.

Each of the six states in Region VIII has American Indian reservations, and from the project's inception, the RAC expressed the need to collaborate and partner with the Indian Health Service and other key partners in the region that serves many American Indians that live throughout the Region VIII state. However, information about delivery of STD and family planning services on the reservations is non-existent.

With regard to the national activity to develop a standardized assessment to provide an epidemiologic and health care delivery system profile, the JSI/Denver sees this as an opportunity to build upon previous and current projects which focus on the STD prevention and reproductive health care needs of Indian populations in Region VIII. JSI will conduct a needs assessment of Indian populations who live on reservations as well as in urban areas in the Region VIII states to determine what STD and reproductive health services are currently being provided on the reservations either by tribal health clinics or by Indian Health Services (IHS) and in urban areas by Urban Indian Health Centers (UIHC). In addition to determining the services that are provided, the assessment will ascertain how much the services are being accessed and by whom. The overall goal of this assessment is to determine how the Region VIII IPP can support STD and family planning service provision to American Indians throughout the region.

The following progress has been made to address this national activity:

- An exhaustive search for federally funded and other healthcare resources targeted at AI/AN populations in the region has been conducted as well as demographic data and data related to STD's and related health indicators. Below is a brief summary of the secondary data analysis:

Within the six states that comprise Region VIII there are over 185,000 Native American people. Almost 60% of these are females and 46% of those females are between the ages of 15 and 44. Health services for the twenty five reservations that are within the Region VIII boundaries are administered through regional Indian Health Services (IHS) offices in Aberdeen (ND, SD), Billings (MT, WY), Albuquerque (CO), Phoenix (UT), and Navajo (CO, UT). According to FY 2007 data from IHS, the average rate of family planning visits for American Indian women ages 15 to 44 years old in all twelve IHS regions was 573/1000. The rates for IHS areas in Region VIII were:

Aberdeen area (ND, SD)	509.8/1000
Billings area (MT, WY)	833/1000
Phoenix area (UT)	479/1000
Albuquerque (CO)	628.7/1000
Navajo (CO, UT)	636.3/1000

Rates of sexually transmitted diseases are rising across the Northern Plains region, and

are increasing in Tribal communities as well. Rates of Chlamydia rose from about 1,200 cases per 100,000 in 2000 to nearly 2,000 per 100,000 in 2004 in the Aberdeen Area IHS service population. Gonorrhea rates rose from about 175 cases per 100,000 in 2002 to 275 cases per 100,000 in 2004.<sup>1</sup>

A regional assessment will be completed to include a comprehensive list of AI/AN targeted resources, and resources utilized by AI/AN populations. This assessment will further enhance the already developed, toolkit, *Building Bridges: Working with American Indian and Alaska Native Health Care Providers to Integrate Reproductive Health, STD, and HIV Prevention Services*. This resource is intended to be used as a general resource for our Regional IPP Committee members who are trying to partners with AI/AN communities to address reproductive health care and STD/HIV prevention needs in both urban and non-urban areas.

B. Development and distribution of a regional epidemiologic profile of pregnancy-test only clients seen in prevalence monitoring clinics.

The regional epidemiologic profile of pregnancy-testing only clients (PTO) seen in prevalence monitoring clinics began with a close examination of FPAR data for Region VIII and ways in which we can make determinations about PTO screening based on existing data sources. Although the FPAR data is not as promising as we hoped it would be, we are continuing to run different analyses with the FPAR data tables in order to make meaningful deductions about the prevalence of Chlamydia screening of PTO clients in Region VIII. Due to the fact that the FPAR data has not been as helpful as originally intended in establishing a baseline for the prevalence of Chlamydia and Gonorrhea screening provided to PTO clients, JSI looked to other internal data sources.

One of those being the Regional Quality Improvement Project (RQIP) for the Region VIII Family Planning Grantees; RQIP. RQIP provides a conceptual framework assessing the quality of family planning services; building upon the work of Donabedian, Judith Bruce developed a framework specifically for assessing the quality of family planning care. Bruce's framework conceptualizes program inputs, six main elements reflecting program activities and outputs, and impacts on clients served. RQIP was developed to assist Region VIII Title X family planning clinics with the collection of quality assurance data for the purpose of improving the services offered by the clinics. Performance measurement/quality assurance data will be collected from Title X family planning clinics across Region VIII and incorporated into a regional database. The data are analyzed and reports, based on the data, are provided to the state grantee to utilize for performance improvement. The Title X Grantees have the course of the 3-year site review cycle to collect the total sample number. Data are aggregated for each state on a yearly basis and rolled up to the regional level for analysis and reporting every three years.

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<sup>1</sup>D. Wong, E. Swint, E. Paisano, J.E. Cheek, *Indian Health Surveillance Report: Sexually Transmitted Diseases 2004*. US Department of Health and Human Services, Centers for Disease Control and Prevention and Indian Health Service, 2004.

A major strength of this project is that the recommended performance indicators will be uniformly collected across the six states and can be used to assess performance of Title X programs both across and within states. RQIP utilizes a defined set of common indicators to evaluate the quality of care provided in Region VIII Title X family planning clinics. The performance indicators utilized in RQIP address **8 domains**:

- Method choice
- Information to clients
- Technical competence
- Interpersonal relations
- Follow-up and continuity mechanisms
- Appropriateness of services
- Access
- Outcome measures<sup>2</sup>

The pertinent domain for assessing the prevalence of Chlamydia and Gonorrhea screening among PTO clients is the Technical Competence domain which measures the appropriate screening for Chlamydia and appropriate follow-up on positive results for Chlamydia. These indicators are measure through a validated and standardized chart audit. Below are the series of questions that are asked for charts audited for all female clients accessing services for both annual/initial reproductive health exams and pregnancy test only visit:

Type of visit:

Annual or Initial  Pregnancy Test

Does the chart have documentation that the client received a Chlamydia screen?

Yes  No  Not Applicable

If client received a Chlamydia test, was the test ordered based on any of the following reasons? (check all that apply)

Client Met Screening Criteria based on age criteria ( $\leq 25$ )

IUD Insertion

Client Was Symptomatic  Client Requested Test

Contact to STD  No Reason Documented

Pregnancy Test

What was the result of the Chlamydia screen?

Positive

Negative

Is there documentation of follow-up of positive results?

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<sup>2</sup> Structural, process, and outcome measures were identified that are obtainable from medical charts, administrative records, and surveys in order to construct a comprehensive set of approximately 15 quality assessment measures specific for Title X clinics. Several areas of focus were drawn primarily from the work of Judith Bruce.

- Yes
- No
- Not in record

If there is documentation of follow-up to positive results, what type of follow-up?

- Client contacted and notified of results
- Treated
- Counseled on partner notification

Preliminary results of the 2008 chart audit are presented below:

- Preliminary analysis of data from 27 Family Planning sites across Region VIII
- Overall Ct positivity for females tested at these sites in 2008, according to chart audit, was 4.2%
- Reviewed a random sample of 308 unduplicated client records for all females seen for an initial or annual visit in 2008:
  - Age composition of charts:
    - 1% (n=1) <15 years old
    - 62% (n=190) 15-24 years old
    - 37% (n=117) >=25 years old
  - 81/308 (26%) charts indicated a pregnancy test during the visit
    - 15/81 (19%) of these clients received a Chlamydia test
    - Resulting in a 6.7% (1 of the 15 tests were positive) positivity

Clearly there is room for improvement in the area to maximize the opportunity to expand Chlamydia screening to this high-risk women.

- In an effort to educate Title X providers about other screening opportunities to maximize screening coverage, the Region VIII IPP Project Director provided an audio-conference:

*Chlamydia Screening Audio-Conference~*

*Providing Cost-Effective Chlamydia Screening to Women Attending Family Planning Clinics in PHS Region VIII*

March 26, 2009

**Topics that were covered:**

- National guidelines
- IPP screening criteria
- Case study—Region VIII
  - FP—Title X Chlamydia testing
- How well are we doing?
- Future issues
- Other screening opportunities to maximize screening coverage

Region VIII IPP *minimum screening criteria* include only those women who have an initial or annual (i.e. pelvic) exam, but is providing a Chlamydia test

during a pelvic exam enough?

- A significant activity of the data workgroup involved reviewing the quality of the data to ensure that appropriate data is being collected in a timely manner in order to enhance our ability to assess meeting screening criteria were to add pregnancy test visit to the reason for visit variable. During the FY 2009 project year, JSI has been working with each program area to modify their lab slips and lab information systems (LIMS) to comply with the collection of the PTO variable and other data collection enhancements. We anticipate all program areas to be compliant with the collection of this variable by January 2010. This will allow the region to monitor the screening practices and positivity among clients seeking a pregnancy test at any of our participating prevalence monitoring sites.

The FPAR data, combined with the results from the RQIP chart audits and the addition of the PTO reason for visit variable, will be combined to create an epidemiologic profile of PTO screening and outcomes for Region VIII.

- C. Summary of current activities designed to improve performance as measured by the IPP infrastructure performance measures.

The Infertility Prevention Project is about the promotion of best practices in screening and treatment for Chlamydia/Gonorrhea among females and their partners in both the public and private sector. The funds awarded through the IPP are intended to support the identification and treatment of infection among the most vulnerable populations [uninsured and underinsured females with >3% CT positivity] as part of a larger public health effort to ensure that all at-risk females, particularly age <26 have access to screening and treatment services. The Region VIII IPP believes that in order to monitor and evaluate our performance in implementing screening and treatment best practices, we should incorporate analysis of regional prevalence monitoring data for regional and local data-directed program planning.

Given that the overarching goal of the IPP is to be agents of best practices, the following key program questions were asked as began to use the two measures of effectiveness to help target Chlamydia /Gonorrhea screening activities to assure that resources are being used in the most cost effective way and that adequate screening coverage is occurring for the highest risk populations of women.

- Are providers appropriately targeting use of CT tests according to national screening guidelines?
- What is the screening coverage among the target population of females  $\leq 25$  yrs?
- How can screening coverage among the most at risk be maximized?
- Given the overall low positivity among females >25 yrs, how can we better identify those at risk for infection?
- How well are we doing?

## 1. Chlamydia Screening Coverage Estimate

Screening Coverage, as estimated by the FPAR data in Region VIII, shows some improvement since CY 2005. The screening coverage in the 15-19 year old age group remained stable at 40% over the past 3 years, and the 20-24 year olds increased by 12% (37% to 49%) while the over 24 year olds decreased by about 3 percent. The data indicates movement in the right direction, and reflects the increased attention to screening criteria and the importance of adherence to them by the IPP project and the Advisory Committee members.

The table below reports an estimate of Chlamydia screening coverage among sexually-active women attending family planning clinics, stratified by standard age groups.

**Chlamydia Screening Coverage**  
CY 2005-2007

	Age Group	# women screened	# women eligible	Estimated Screening Coverage (%)
CY 2005	15-19	17,446	43,578	40%
	20-24	20,155	52,089	37%
	>24	13,394*	52,218**	26%
	<b>TOTAL</b>	<b>50,995</b>	<b>147,885</b>	<b>34.5%</b>
CY 2006	15-19	18,699	46,750	41%
	20-24	20,807	52,899	39%
	>24	13,997*	51,088**	27%
	<b>TOTAL</b>	<b>53,503</b>	<b>150,737</b>	<b>35.5%</b>
CY 2007	15-19	15,221	37,708	40%
	20-24	18,274	37,161	49%
	>24	11,826	51,382	23%
	<b>TOTAL</b>	<b>45,321</b>	<b>126,251</b>	<b>35.8%</b>

\*Agegroup is 25 and over

\*\*Agegroups are 25-29, 30-34, 35-39, 40-44, Over 44

Regional Performance Goal

By the end of the fiscal year 2010, among clients attending family planning clinics, the number of women screened in the 24 and under age group will be increased by at least 5% from 44% to 49% and will decrease by at least 3% in the over 24 age range from 23% to 20%.

Rationale

Setting a performance goal of a 3% increase in younger women being screened is realistic based on the percent change that occurred between 2005-2007. Further analysis and data collection is ongoing in this area. Advisory Committee meetings, workgroup meetings, clinic-specific data reports, and regional trainings will all emphasize the need to improve this performance measure.

**2. Chlamydia Screening Test Utilization**

Screening Test Utilization data show less improvement than for the Screening Coverage data, in fact the numbers have remained stable since the beginning of data collection for this measure. There are several possible explanations for this, first, is that given the reductions in funding of recent years, the screening test utilization may be static in that

that even with more targeted screening and the improvements in adherence to screening criteria reflected in Screening Coverage measure, this is a *proportion* and so it remains stagnant. Secondly, the data here do not include risk factors and the screening criteria for the region reflects the national CDC recommendations that women over 25 should be screened with risk factors. The Region VIII IPP infrastructure hopes to elicit other possible explanations from the RQIP chart audit described above in the PTO national activity summary.

The table reports a proportion of Chlamydia screening tests performed among women <26 years of age.

**Chlamydia Screening Test Utilization**  
CY 2005-2007

	Age Group	# by age, group female tests utilized	Proportion of female tests utilized, by age
CY 2005	15-19	15,348	33%
	20-24	19,315	41%
	25-29	6,385	14%
	> 29	5,518	12%
	<b>TOTAL</b>	<b>46,965</b>	<b>NA</b>
CY 2006	15-19	10,104	27%
	20-24	17,208	45%
	25-29	6,084	16%
	> 29	4,460	12%
	<b>TOTAL</b>	<b>37,856</b>	<b>NA</b>
CY 2007	15-19	15,439	31%
	20-24	20,287	41%
	25-29	7,157	15%
	> 29	5,883	12%
	<b>TOTAL</b>	<b>48,766</b>	<b>NA</b>

Performance Goal

By the end of fiscal year 2009, among clients attending Family Planning Clinics, the proportion of female Chlamydia tests utilized by women between the ages of 15-24 and will increase from 73% to 80% and the number provided to those 25 and older will decrease by from 26% to 23%.

Rationale

Similar to screening coverage, the increase in tests done on young women is less complicated than decreasing screening done on older women. A performance goal of increasing screening coverage to 35% in the targeted age groups of 15-19 and 20-24 year olds is reasonable given the concurrent education efforts by the Advisory Board. But screening criteria is not based on age alone, but also incorporates risk factors. Therefore, one would not want to see the proportion of tests done on older women drop to zero, but rather drop to the proportion that reflects the number of women with risk factors in that age group. The drop in prevalence is most clear in the over 29 age group, and so the drop in tests is also expected to occur less in this middle age range than in the oldest (> 29 age group). Based on the 2008 RQIP chart audits results showing that 93% of the charts

audited indicated adherence to the National and Regional screening guidelines, it should be possible to continue the slow but positive trend of decreasing the proportion of tests in the over 29 year old age range and increasing the proportion done in the highest risk or target age range. Our proposed intervention and education campaign for 2009-2010 would be aimed at an improvement on both of the performance measures.

### 3. Action Steps for Both Performance Measures:

JSI/Denver, in collaboration with the Steering Committee of the Region VIII IPP, will develop regional guidance and funding allocation formula in order to increase screening coverage in identified and prioritized high risk populations. This will be accomplished through the following activities:

- Conduct a regional assessment of the current screening criteria; do they vary by state?
- Conduct an analysis of the proportion of women being screened using current criteria and proportion of infections being identified by these criteria.
- Pilot formula using the previous year's data and present findings at the fall 2010 meeting.
- The pilot will result in the distribution of best practice guidelines for funding allocations based on a 3% positivity threshold which is maintained for three years, while also reaching at least an 80% screening coverage rate.
- Dissemination of the Chlamydia/Gonorrhea screening reminder card, PATH.