NYC STD HIV Prevention Training Center
Routinizing Sexual Health Into Primary Care: Models for FQHCs Webinar

Moderator: Gowri Nagendra
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Gowri Nagendra: Good afternoon and thank you for joining us today for today's webinar, Routinizing Sexual Health into Primary Care: Models for Federally Qualified Health Centers. Next slide.

All webinars in this series will be archived and they all provide free CME and CNE credits. Please visit our Web site for information on upcoming webinars. This webinar is the first in a series of sexual health webinars sponsored by the Federal Training Center Collaborative. Next slide, please.

The Training Center Collaborative includes the training centers listed here and our goal is to maximize federal training and technical assistance resources to meet the needs, the training needs of providers around key sexual and reproductive health issues. Next slide, please.

This webinar has been accredited for both Continuing Medical Education and Continuing Nursing Education credits, as listed before - below. Information on accessing continuing education will be emailed to you after the webinar is completed. Next slide, please.

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Dr. Gale Burstein's presentation will include discussion of unlabeled use of gonorrhea and Chlamydia Nucleic Acid Amplification Testing of non-genital specimens that are not FDA approved. Clinical labs may conduct validation studies to obtain CLIA approval to perform these tests. CDC does not accept commercial support. Next slide, please.

Questions for the webinar may be asked via the chat box located on your screen. Please feel free to type in questions during the webinar and we will answer as many questions as time permits at the end of the webinar. Next slide, please.

And now, I'd like to turn it over to our presenter, Dr. Gale Burstein. Dr. Burstein is the Erie County Commissioner of Health in New York State and Clinical Professor of Pediatrics at SUNY Buffalo School of Medicine and Biomedical Sciences. Dr. Burstein is currently working on strategies to improve access to primary and sexual healthcare services in underserved areas of Erie County. She is board certified in adolescent medicine and has been published in various scientific journals, including JAMA, Pediatrics, Obstetrics and Gynecology, and Sexually Transmitted Diseases. Welcome, Gale. Next slide, please.

Dr. Gale Burstein: Thank you, Gowri, for that nice introduction and good afternoon to everyone viewing this webinar. We know that talking about sexual behavior is always a great thing to do after lunch, so glad you can join us. So, in the next 45

minutes, I will be talking about why it is so important to routinize sexual healthcare into primary care by showing you data about how many of your patients, including adolescent patients, are probably engaging in some type of sexual activity to prove that it is so important that we talk about this issue during the healthcare visit.

But sometimes, this can be a difficult conversation, especially to initiate and especially with adolescent patients accompanied by an adult. So, I will also provide some strategies and tools. Since confidentiality, consent, and even time alone with your patient can even be more of a challenge with adolescent patients, I will focus my talk on adolescent issues. But these strategies and resources can really be used with any age group. At the end, we should have time to discuss some questions.

I would like to acknowledge CDC's Division of STD Prevention, the New York City Department of Health and Mental Health, and the New York State Department of Health for their assistance and data. And I would especially like to thank the New York City STD HIV Prevention Training Center for sponsoring this webinar.

So, first let's get to know each other. You've already heard probably more than you want to know about me. So, I'll ask a few questions about you -- nothing too personal and I promise I will not ask a sexual history.

So, first, this is a poll. So I'd like you to fill in which response is most appropriate for you. So, first I'd like to know in what type of clinical setting you work. Is it a federally qualified health center, other community health center, a school-based health center, a health department, a hospital, a private practice, or some other type?

Okay, I'm going to close the poll. And let's see what we have. So, we see I guess most people, many people work in health departments and then other types of clinics.

Okay, so, the next question is I want to know what type of provider are you. Are you a physician, a physician's assistant, a nurse practitioner, a registered nurse, a licensed practical nurse, or something else?

Okay, I'm going to close the poll. And let's see. We have a lot of others. Great.

Okay, so next I'm going to ask - just want to get an idea where you all are from. So, are you from New York State or from outside New York State or from one of the U.S. territories like Puerto Rico, the U.S. Virgin Islands, Guam or American Samoa?

Okay, I'm going to close the poll. And I guess there are a lot of people both from New York State and outside of New York State. So, great, welcome.

And then, one other question. I just want to try to figure out how many people are out there. So, can you let me know how many people are watching the webinar on your same computer? Is it 1 to 5, 6 to 10, 11 to 20 or over 20?

Okay, I'm going to close the poll. And it's usually one to five people, great.

Okay, and last question: Do you routinely offer in your clinic setting - what do you routinely offer in your clinic setting: A sexual history, an STD screen, contraception counseling, contraception prescriptions, or all of the above?

Great. I'm going to close the poll. And that's - these are great responses. Looks like a lot of people on the - on this webinar are already providing routine sexual healthcare services. That's great news.

Okay. So, now we have an idea of who we all are. So let's talk about why sexual health matters for our patients in primary care.

We believe that there are nearly 20 million STD cases that occur each year in the United States and they disproportionately affect young people and racial and ethnic minority populations. The cost of these infections are not trivial. CDC estimates 15.6 billion dollars in annual direct medical costs of treating STDs and their sequelae. STDs can cause serious health problems, including ectopic pregnancy, infertility, chronic pelvic pain, increased risk of HIV infection, certain cancers from HPV, and congenital diseases in infants born to infected moms.

Let's discuss what our patients, including adolescents, are doing that places them at risk for STDs. So these are data from the National Survey of Family Growth, which is a large household-based survey of U.S. males and females 15 to 44 years old, conducted by the Centers for Disease Control and Prevention's National Health Center for Health Statistics that obtains information on factors affecting birth and pregnancy rates. These data illustrate the diversity in sexual behavior with opposite sex partners among females age 15 to 44 years. You can see that almost 50 percent of adolescents and most adult females are engaging in vaginal sex and/or oral sex and a smaller, yet significant, proportion are engaging in anal sex.

These are National Survey of Family Growth data from 15 to 44 year old U.S. males asking about sexual behavior with female partners. Again, many

adolescent and adult males are engaging in vaginal and/or oral sex, and a significant proportion are engaging in anal sex with their female partners.

These are also data from the National Survey of Family Growth that present the sexual behaviors with same sex partners among males age 15 to 44 years. You can see that the prevalence of same sex behavior among males is high enough where you should expect to see male patients in your practice who are engaging in sex with other males. But you are never going to know if you don't ask.

It is also very important to know what type of sex your patients are practicing so you know which orifices to test for STIs. We have to routinely ask the question of our patients who report sexual activity, "Are you having vaginal sex, oral sex, or anal sex," to guide your clinical practice. If you feel comfortable with the question your patients will feel comfortable with the question. If you only screen a urine specimen from someone only engaging in receptive anal or oral sex, you will completely miss these infections.

Now, let's look at the prevalence of an outcome of sexual behavior, which is sexually transmitted infections. So, although adolescents and young adults account for only 25 percent of the total U.S. sexual active population, they account for 50 percent of new sexually transmitted infections. And 88 percent of these new STI cases are from three infections -- HPV, trichomonas, and Chlamydia.

So, let's look at who is affected by STIs in New York City and the rest of New York State. For the sake of time, I will alternate showing (epi) data from New York City and New York State, but the curves look the same pretty much everywhere in New York State.

So, this is a population pyramid presenting Chlamydia rates in New York City by age and gender. The X axis corresponds to race per 100,000 population and the Y axis corresponds to age in groups. On the right-hand side in pink are females. On the left in blue are males. You can see that the highest Chlamydia rates are reported among adolescent and young adult females.

This is a similar graph presenting gonorrhea rates in New York City by age and gender. Again, you can see that the highest gonorrhea rates are reported among adolescent and young adult males and females. We believe we are seeing more gonorrhea reported among males because males are more likely to be symptomatic with gonorrhea compared to Chlamydia and, thus, coming into care for testing.

These are now data from New York State looking at the age distribution of newly diagnosed HIV cases in 2011. Along the X axis is age and along the Y axis is percent of new cases. Red corresponds to females and blue to males. And you can see that among males there seems to be a surge of new HIV cases in young males, whereas females' rates are pretty steady with a small uptick among women in their 40s to 50s. You will see in the next slide that in New York State and New York City we are seeing many newly diagnosed HIV cases in young men who have sex with men of color.

This slide shows the number of new HIV diagnosed cases by risk factor and gender. On the left in red are females where you can see that the majority infections are believed to be due to heterosexual contact; whereas, on the right among males, in blue, the vast majority of infections are from having sex with other men.

I also want to call your attention to the total number of new infections by gender. There are over three times more new HIV infections among males

compared to females and most of these new male infections are from same sex contact. Again, it is so important to ask a good sexual history, including questions about partner.

This pie chart on the left shows data looking at where Chlamydia is being diagnosed in New York State outside of New York City in 2012. You can see that half of all the Chlamydia infections are being diagnosed in - by primary care providers, which are private providers and community health centers in this chart.

The pie chart on the right shows data looking at where gonorrhea is being diagnosed in New York State outside of New York City in 2012. You can see that a third of all gonorrhea infections are being diagnosed by primary care providers. We in primary care are the front line providers to screen and identify gonorrhea and Chlamydia for the population at risk.

Now I will discuss strategies that most primary care providers can use to routinize sexual healthcare services. I'm going to focus on the adolescent visit because I think that it's the most challenging with parents, developmental issues, and confidentiality.

In terms of confidentiality, we found that the best way to handle confidential services is actually through full disclosure. And what I mean by that is to fully disclose upfront to the teen patient and accompanying adult your office's confidentiality policy and you plan to have some private time with the teen during the office visit. If families know upfront and are expecting this, we find that they readily accept these services.

So, I want to remind everyone about New York State minor consent laws. In New York State, minors are allowed to consent for their own care for

pregnancy prevention, sexually transmitted infections, obstetrical care, care related to sexual assault, mental health as an outpatient, and substance abuse care as an outpatient. If you live outside of New York State, a great place to check the status of your minor consent laws is on the (Good Macher) Web site at the bottom of this slide.

So, remember, if a minor consents for these services themselves all the related health records are protected health information, so a parent or legal guardian does not have access to this information unless the minor grants permission. This gets even less clear when we talk about insurance-related information.

So, even in an office that has confidentially - has the confidentiality piece figured out and everyone in the office is onboard, providers still cannot guarantee confidentiality in many cases. Explanation of Benefits or EOBs may be sent to the primary insured, which is usually the parent or guardian, by the health plan. Although in New York State the medical information listed in the EOB is not specific to the type of visit or what specific tests were done, it does alert the primary insurer the visit and/or tests were done, which could trigger further inquiries.

The good news is that in New York State the teen patient may request that the health plan send the EOB to an alternative address and New York State mandates that the health plan must comply with this request. However, if the adolescent has the self-efficacy to call the health plan and figure out how to get this done, this will require programming and can take several weeks to get into place. So, that day's visit will probably not be sent to the alternative location. So, providers should be aware of the paper trail issues in their health system.

More good news is that some health plans do not send Explanation of Benefits. New York State Medicaid does not routinely send EOBs. New York State health plans are not legally obligated to send EOBs if only a copayment is due or nothing is due, such as for a preventive healthcare visit or contraception. However, we have no control over bills or statements that are sent directly from the labs. These are not regulated.

The Family Planning Benefit Program is a Medicaid waiver health plan for New Yorkers that covers family planning services. It's intended to increase access to confidential family planning services for teens, women, and men of childbearing age. Patients can be eligible for the Family Planning Benefits Program even if they are already covered by another health insurance. So, kids can be dually insured with their parents' plan and their own (FPBP), which covers family planning services to avoid any disclosure through insurance.

So, in the next part of this presentation I'll be presenting some tools to help providers with screening and addressing confidentiality that are available on public domain Web sites that will be listed at the end of the presentation and on the New York City PTC Web site.

So, this is a letter for families that explains the adolescent healthcare visit that you can send to families before the visit or give them when they register. It's available in a Word document so you can personalize it to your own office. You can put your office name and logo on the top and then next list the services that your office may offer. If your office does not offer all these services, you can just delete that from the letter.

The letter explains why it is important to provide confidential services and briefly touches on your state's minor consent laws. If you work outside of New York State you can get your state's Use Risk Behavior Surveillance

Survey data from the CDC Web site and your state's minor consent law information from the (Good Macher) Web site.

We have found in Erie County that parents really appreciate this head's up. If parents are notified ahead of time of these confidential services, then so far in our experience they have not become angry and these services are being delivered rather than finding out that they've been delivered after the fact by receiving an EOB.

So, you can also put this letter on your office Web site.

Now, I will present some risk assessment tools that are used by primary care providers to assess adolescent health risk and protective behaviors. These include questions about sexual behavior to help providers incorporate into the routine visit. Of course, these are confidential questions that you want to ask when parents are not present.

At the very beginning of the visit, I always let the family know that I ask the adult the leave the room while I do the physical exam to give the teen some privacy and allow them to practice speaking with their healthcare provider. I remind parents that in a few years their teen will be an adult and have to do this themselves. I point out that this is a good opportunity to practice, so they feel comfortable when they are 18.

An easy way to remember the categories for questions is to ask using the HEADS pneumonic. The (shades) is the HEADS tool that has been modified to ask questions about strengths and assets rather than just focusing on risk. We want to know from the teen what is good about them and not just their negative risk.

New York State Department of Health sponsors the development of this brief confidential adolescent screening questionnaire. Here is the first page. It is 16 validated questions in - written in a very low reading level. The patient can completely - can complete during the triage and the provider can scan the response before walking in the room to know what questions need to be asked. These are just screening questions. If a patient gives a positive response, the provider needs to ask more questions about that issue.

So, if the patient responds that they have had sexual intercourse, of course the provider needs to ask more questions to help guide testing and to assess the need for contraception counseling. So, a great pneumonic to remember what questions to ask in the sexual history is the five Ps and that is described in the CDC STD Treatment Guidelines: Partners, such as gender and number; practices such as vaginal, anal or oral sex; past history of STDs; pregnancies, such as what the patient is doing to prevent pregnancy; and protection, such as asking about condom use.

There are actually evidence-based guidelines for routine STI testing that are published by the U.S. Preventive Services Task Force and some by CDC. Currently, the U.S. Preventive Services Task Force, CDC, the American Academy of Family Physicians, the American Academy of Pediatrics, and other medical associations recommend screening all sexually active females under the age of 25 annually and to screen women aged 25 and older if they're at increased risk.

Increased risk is defined as having new or multiple sexual partners, history of Chlamydia or other sexually transmitted infections, inconsistent condom use or exchange sex for money or drugs. Certain demographics also have a higher prevalence of infection than the general population in many communities and

settings such as African American and Hispanic women, incarcerated populations, military recruits, and patients seen at public STD clinics.

Even with these evidence-based national guidelines, we are still falling short on screening many young women at risk. These are Chlamydia screening data from the National Center for Quality Assurance Health Care Effectiveness Data and Information Set or HEDIS. HEDIS is a tool used by more than 90% of Americans' health plans to measure performance on important dimensions of care and service.

The Chlamydia HEDIS measure estimates the proportion of sexually active females enrolled in health plans who were screened. In this graph, the X axis corresponds to the year of enrollment and the Y axis corresponds to the percentage of females screened for Chlamydia. Green corresponds to Medicaid covered patients and red to commercial health plans. Solid line corresponds to females 21 to 24 years, and dotted line to 16 to 20 year olds.

You can see that although we are doing a better job over time with Chlamydia screening females under 25 years, after over ten years of observation we still only reach about a half of females at risk who are enrolled in care. In general, we are doing a better job with Medicaid insured compared to commercially insured patients and patients in their early 20s compared to their teens.

The U.S. Preventive Services Task Force Gonorrhea Screening Guidelines are not as clear. They recommend screening all females at risk of infection who they identify as females under age 25 years, a previous gonorrhea infection or other STIs, new or multiple sexual partners, inconsistent condom use, sex work, or drug use.

Although they identify that African Americans and men who have sex with men have higher prevalence of infection than the general population in many communities and settings, the U.S. Preventive Services Task Force concluded that there was insufficient evidence to recommend for or against routine gonorrhea screening any males at increased risk for gonorrhea. The U.S. Preventive Services Task Force has begun the process to review and revise the current Chlamydia and gonorrhea screening recommendations. So, stay tuned.

So, I'm sure many of you noticed that the U.S. Preventive Services Task Force did not make recommendations for screening males for Chlamydia and gonorrhea. Because of the feasibility, cost and efficacy of making efforts to bring males into care for Chlamydia screening when we don't even do a good job with Chlamydia screening females who are already in care, it is not cost effective to screen all males routinely for Chlamydia, especially since males rarely develop any symptoms or sequelae.

However, a CDC external (consultation) did find evidence that it was cost effective to screen males for Chlamydia who are likely to infect many females. So, CDC recommends Chlamydia screening males under the age of 30 seeking care at locations with high Chlamydia prevalence such as STD clinics, correctional facilities, urban adolescent clinics, or school-based clinics, who have multiple partners so are likely to infect others. The Web site for these recommendations are on this slide. Given high re-infection rates, the highest risk males are partners of Chlamydia infected females.

CDC also has gonorrhea and Chlamydia screening recommendations for males who have sex with other males. These are very specific based on type of sexual behavior in orifices that are exposed. Again, it is so important to take a sexual history. CDC recommends urethral gonorrhea and Chlamydia screening in males who have insertive intercourse with a urine Nucleic Acid

Acidification Test or a NAAT test, rectal gonorrhea and Chlamydia screening in males who have receptive anal intercourse and a NAAT of a rectal swab is preferred, and pharyngeal gonorrhea screening in males who have receptive oral intercourse with a NAAT of an oral swab.

Now we have opportunities to prevent STIs with immunizations such as HPV, hepatitis A and B and should encourage these vaccines for eligible patients. We should also provide sexual information to our patients as part of healthcare. Although this has traditionally been done with face-to-face counseling that can require a lot of time, you can also provide this information in other formats such as providing a list of valid informational Web sites so teens can seek more information on their own. Also, the U.S. Preventive Services Task Force recommends high intensity STD prevention behavioral counseling for all sexually active adolescents and for adults at increased risk for STIs.

Since people, especially adolescents, like to go to the Internet for health information, here is an example of a brochure with a list of valid sexual health Web sites for teens and parents. You can put these Web sites on your practice's Web site for your patients to access.

Now, we will review some resources for practitioners that are available from CDC, AAP, the National Chlamydia Coalition, and the Physicians for Reproductive Health. CDC has the STD Treatment Guidelines with evidence-based recommendations for STI testing, treatment, and prevention. The STD Treatment Guidelines App is an easy to use reference that helps healthcare providers identify and treat patients for STD. This free app is available for Apple and Android devices.

The American Academy of Pediatrics offers great handouts and tools, including those I presented on their section on Adolescent Health Web site. Bright Futures is AAP's National Health Promotion and Disease Prevention Initiative that provides adolescent screening tools and strategies on how to routinize adolescent screening into primary care. Also, the American Academy of Pediatrics' New York District publishes a Teen Healthcare Bill of Rights that informs teens about what they need to know about minor consent laws in New York State and confidentiality. You can contact the AAP New York State District Office for copies. And here is an example of the information included in the brochure.

The National Chlamydia Coalition has a lot of great resources for patients and providers. Why Screen for Chlamydia covers the latest information and tools for healthcare providers to improve delivery of Chlamydia screening and make Chlamydia screening and care a routine part of medical practice. This guide tells you everything you need to know to organize your office to routinely screen and takes you from when the patient directly enters into your office until you have to notify your patient of a positive Chlamydia test and counsel them on Expedited Partner Therapy.

The Physicians for Reproductive Health offers Minor Access Cards free to download on their Web site that summarizes the complex laws surrounding the provision of reproductive health services to minors in 13 states, including New York State and are available as a PDF.

So, now let's spend a few minutes on STI tests. CDC strongly recommends doing a NAAT to test for gonorrhea and Chlamydia. This is by far the most sensitive test with the most options for specimen type. While there's a great deal of choice in terms of sample type, the preferred specimen for Chlamydia

screening for females is a vaginal swab, including a self-collected vaginal swab as a non-invasive specimen for females.

Urine specimens are fine. If your office has a system down where you are collecting the urine specimen routinely and sending it for Chlamydia testing, don't try to fix it if it's not broken. But you can ask the females to collect a vaginal specimen on themselves and it will be a bit more sensitive.

For males, the specimen of choice is a urine for NAAT testing. But remember that CDC recommends routine non-genital gonorrhea and Chlamydia NAAT testing for men who have sex with men. But these tests are not FDA-approved. However, clinical labs can do their own verification studies to get CLIA approval to perform these tests in their labs.

You can see from the data presented in this study published a couple of years ago that the NAATs in the first three rows are much more sensitive for rectal Chlamydia testing in the first column and gonorrhea testing in the second column compared to cell culture on the bottom row. If a provider uses cell culture for rectal Chlamydia screening, they would miss half of infections and for rectal gonorrhea screening they would miss about a quarter of infections.

The same is true for pharyngeal gonorrhea testing. You can see that in the first three rows the NAATs are much more sensitive compared with cell culture on the bottom row. A third of pharyngeal gonorrhea infections would be missed if providers use cell culture instead of NAATs.

Large labs like Quest and LabCorp have CLIA - are CLIA approved already to do these tests and have lab codes and also there are CPT codes available. Other labs, such as public health and hospital-based labs, also can perform these tests. So, you should check with your clinical laboratory.

So, now I'll briefly talk about tests for vaginitis, both Rapid CLIA-Waived tests and clinical lab tests. The OSOM BVBlue Test and the OSOM Trichomonas Rapid Test are CLIA-Waived point of care vaginitis tests with results available in ten minutes.

The OSOM BVBlue Test detects elevated vaginal fluid enzymes produced by bacterial pathogens associated with BV and turns blue or green in the testing vessel if it's positive. The OSOM Trichomonas Rapid Test works just like a Rapid Strep Test except the swab is from a different orifice. One line is a valid negative test and two lines are a valid positive test on the testing strip.

Also, Gen-Probe has an assay to NAAT test for trichomonas on any specimen sent for female gonorrhea or Chlamydia testing. Labs can do validation studies to get CLIA approval to perform this test on males. The Affirm VPIII is a DNA probe test that tests for pathogens that can cause vaginitis and both tests are sent out to clinical labs.

I just want to (unintelligible) attention to the Web sites where these - most of these resources are available that are also going to be available on the Prevention Training Center's Web site.

Gowri Nagendra: Thank you so much, Dr. Burstein. And thank you so much to all of you for participating today. We will be sending out information on accessing CME and CNE to you at - once the webinar has been concluded. You must complete the online evaluation by October 14 to receive your continuing education credits.

And so, we want to point your attention to the upcoming webinars. The next one will be scheduled for September 25 from 12:00 to 1:00 and it's focused on

the STD Treatment Guidelines with a focus on GC. You can go to our Web site for more information and to register.

So, now we're going to turn it over to some questions. And just a reminder, you can type in your questions in the chat box at the bottom left of your screen.

So, we do have a question here about parents and confidentiality. Dr. Burstein, do you have any suggestions on how to try and get a parent out of the room so that you can talk to the adolescent one-on-one?

Dr. Gale Burstein: Sure. Well, there are a few different strategies. I mean, first of all, as I mentioned in the webinar just letting the parents know at the beginning of the visit that you routinely ask parents to leave the room during the physical exam just to give the adolescent some private time and, you know, some privacy and to allow them to have an opportunity to practice talking to their healthcare provider by themselves because, again, it's kind of like training (wheels) that, you know, the parent's going to be there and so, if there's a problem, if they have trouble you can always call them back.

And so, if you let the parents know upfront that you're going to be doing this and, you know, what you're going to be doing and also reassure the parent that, you know, if there's - you find out anything terrible that, you know, you can bring them back into the loop. You know, usually parents are very accepting of this process and they actually are usually, you know, very thankful that you're doing this and - because usually, you know, they may not be having these conversations with their adolescents at home.

Gowri Nagendra: Great, thank you. And a second question is about refusal of STD testing and perhaps how to bring that up with the adolescent patient on the next visit to try to get them tested.

Dr. Gale Burstein: Sure. Well, you know, again if the adolescent refuses testing, again you can - you know, there could be different reasons why. They may be concerned about confidentiality. They may perceive they're not at risk. So, you know, again let them know that this is something that you offer all your sexually active adolescent patients and also you can reassure them that New York State this is confidential information and so, you know, parents are not entitled to this information.

However, the adolescent may be correct in that parents could find out that a test was done through a billing statement from the lab. So, in those cases you may want to have a, you know, a plan B and a referral site to refer adolescents, like a family planning clinic such as Planned Parenthood or a health department family planning clinic or a federally qualified health center where they can get the services for free or low cost. And also, you can encourage them to enroll or help them to enrolling in the Family Planning Benefits Program where they could have their own health plan for sexual healthcare.

Again, it's always great to bring it up at the next visit. Just because somebody says no once doesn't mean they won't be ready to have the test the next time they come in.

Gowri Nagendra: Great, thank you. Next question we have comes in. It's actually more of a comment on the Chlamydia screening guidelines. And just wanted to get your perspective on the recommendations to screen all females 15 to 24 for

Chlamydia regardless of whether the patient has been sexually active or not. So, just wondering if you have any thoughts on that, Gale.

Dr. Gale Burstein: Well, that's tough. So, the U.S. Preventive Services Task Force currently recommends screening all sexually active females under the age of 25 and CDC recommends screening all sexually active females 25 and under. So, I guess the question is, you know, are you getting the truth? Do you really know that they're sexually active or not?

So I guess that's pretty much a judgment call with the provider. You know, you can - I mean you - one of two things. You can, you know, ask the adolescent if they want a Chlamydia regardless if they want - if they tell you that they're sexually active or not. Say that you offer this to everybody. And many times, if they don't feel comfortable disclosing to you that they're sexually active but they really are, they, you know, they'll probably opt for the STD test.

So, I guess you have to probably feel a little bit - you know, know your patient population. I mean if you decide to maybe just do a trial and routinely screen all females, regardless of what they say about sexual activity under the age of 25 and you see that you're getting positive tests in females who denied sexual activity, maybe that's a policy you may want to start.

So it's really different, you know, based on your population and what your patient relationship is. But, you know, there are a couple ways to skin a cat so you just have to figure out what works in your patient population.

Gowri Nagendra: Great, thank you. The next question is about partner management. And if you have an adolescent patient who comes into your office and she is no longer

with her partner, who is infected and doesn't want to talk to him, do you have any suggestions on how to manage the situation?

Dr. Gale Burstein: Sure. Well, you know, again you can try to get your patient to be altruistic and say, you know, acknowledge that, you know, she may be - she or he may be very upset about getting an infection from their partner when, you know, they weren't aware. But, again, you wouldn't want somebody else to have the same problem and to, you know, to be, you know, a victim and get infected by the same person. So, to protect this new potential partner that, you know, hasn't done anything wrong to anybody, you know, it would be in - you know, it would be, you know, a good deed for the patient to provide treatment to their partner even though they may not be talking to them again.

Also, another strategy is to see if you can give that information about the partner to the Health Department. Maybe they might have the resources to help you out with that. Or sometimes Health Departments may have resources to perform partner notification on selected cases of Chlamydia infection.

So, again, those are all strategies. But it's tough because obviously your patient has that information about their partner and so we're just relying on them to be altruistic and, you know, try to get that partner treated for their partner's health and then also for their partner's future partners' health.

Gowri Nagendra: Great, thanks so much, Gale. And I think related to that there is a resource called inSPOT which you can go on a Web site and anonymously notify your partner that they may have been exposed or infected. So that's another way possibly of getting around, you know, not being able to or wanting to talk to your partner.

Dr. Gale Burstein: Right. That's a great point, Gowri, and that resource is available on the CDC's Division of STD Prevention Web site.

Gowri Nagendra: Great. So, related to that our next question is about Expedited Partner Therapy. And just wondering if you could comment on who is eligible for that.

Dr. Gale Burstein: Well, in New York State anybody is eligible for Expedited Partner Therapy if they have been, you know, diagnosed with Chlamydia infection. It's better to have somebody who has a positive Chlamydia lab test instead of just treating them syndromically. But, you know, in those cases we can offer Expedited Partner Therapy.

Again, it's really important to offer that with counseling and to encourage the patient to, you know, to encourage their partner to still go in and get a full comprehensive STD screening because they may have something else besides Chlamydia. Also, if it's a male delivering Expedited Partner Therapy to a female, you really want to emphasize that because the female, you know, may have PID or may be pregnant and you really don't know.

CDC and the New York State Department of Health discourages using Expedited Partner Therapy with men who have sex with men, just because there are so many STIs, including HIV, in same sex sexual networks -- MSM -- that, you know, you're really at risk of just, you know, partially treating just somebody for Chlamydia where their partner may have HIV and really needs to get into care and get tested. So, for those reasons it's - in New York State and also the Centers for Disease Control and Prevention really encourages providers and partners to try to get partners of men who have sex with men in for care and to get comprehensive screening, including HIV screening.

In New York State, Expedited Partner Therapy is not legal for any other sexually transmitted infection, including gonorrhea. But for people in other states, you can check the CDC's Expedited Partner Therapy Web site where they have a map of New - of the United States that lists what - where Expedited Partner Therapy is legal and what the law says about which STD it's legal to perform. Some states it's only legal for Chlamydia. Some states it's legal for Chlamydia and gonorrhea. Some states leave it pretty much open to any STD. In some states it is not legal. So, you really have to know the laws in your own state.

Gowri Nagendra: Great, thank you, Dr. Burstein. So, I think this one's kind of related to a previous question that was asked. But there is a question about how to get adolescents back for follow-up appointments or to come back to get them retested and things like that. Do you have any suggestions on getting adolescents back?

Dr. Gale Burstein: Yes.

Gowri Nagendra: And perhaps that relates a little bit about building a relationship with that adolescent.

Dr. Gale Burstein: Right. You're right. That is really tough. I mean a couple of - one strategy that we've used with our university STD screening program is that we found when we asked the, you know, the college students to return in two or three months' time they just never came back and they even said that they forget they even had a Chlamydia or gonorrhea infection. So, it seems like they, you know, they had amnesia to the experience.

But, if we asked them to come back in a month's time and we contacted them by email or text like two or three weeks after we treated them, then it was kind

of more in their immediate memory and it was still kind of an, you know, an issue on their radar screen and then we were really able to increase our return rate if, you know, we had them come back in four to six weeks' time. So, that helped a lot. Also, explaining to them why it is so important to return for a repeat test, that they're so at risk for another infection also I think helps get some buy-in.

But, if they don't come back specifically for repeat testing, you know, anytime they return for any other reason is still an opportunity just to collect a urine or a quick vaginal swab and do the test, even though that might not be the reason for visit.

Gowri Nagendra: Great, thank you, Dr. Burstein. It looks like we are actually pretty much all done with questions. Dr. Burstein, did you have any additional thoughts?

Dr. Gale Burstein: Yeah. I think that one of the key strategies to figuring out how to do the, you know, routinized Chlamydia testing as your practice is, you know, even if someone has, you know, the tools and all the resources and the strategies, I think it's really important to work it into your regular system flow of your office setting. And so, if you, you know, routinize it and say it's, you know, part of the nursing task to provide the screening questions and it's part of the nursing task, say at triage, to collect a urine specimen and then for the nurse to, you know, automatically, you know, send the test with the patient's permission if they answer on the screening questionnaire that they are sexually active. And you really kind of take it out of the hands of deciding whether to do it or not if you make it, you know, a routine procedure that's really part of your standard operating procedures. It makes it so much easier to get the job done.

And also, it's important I think to, you know, revisit the changes you make in your offices to enhance Chlamydia screening maybe, you know, every so often -- once a month -- until you really feel confident that you have it down. But, I think the trick is really how to figure out how to make systems changes in your office to make it work.

Gowri Nagendra: Great, thank you so much, Dr. Burstein. That was a really informative and interesting presentation.

Just as a reminder, we will be sending out information on accessing the continuing education credits as well as a copy of today's presentation slides. And you may visit our Web site to learn more about upcoming webinars in this series and to register for any additional webinars. We will also be posting many of the resources that Dr. Burstein discussed on today's webinar and links. So, please visit our Web site for more information.

We just want to thank everyone again for joining us today and we hope that you enjoyed the webinar today. Thank you.

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