State of New Hampshire
Department of Health and Human Services

New Hampshire Annual Quality Meeting

September 1, 2023

HSAG HEALTH SERVICES ADVISORY GROUP

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Acknowledgements

Health Services Advisory Group, Inc., confirms that no one organizing the New Hampshire Quality Meeting activities had a conflict of interest with **AmeriHealth Caritas New Hampshire** (**ACNH**), **New Hampshire Healthy Families** (**NHHF**), or **Well Sense Health Plan** (**WS**) health plans.

1. Introduction

On May 23, 2023, The New Hampshire Department of Health and Human Services (DHHS) held a virtual annual quality meeting with representatives from DHHS, the managed care organizations (MCOs), and providers' offices. Health Services Advisory Group, Inc. (HSAG), the external quality review organization for New Hampshire, assisted DHHS by organizing and coordinating the virtual meeting.

The purpose of the meeting was to discuss issues impacting the following Healthcare Effectiveness Data and Information Set (HEDIS®)[1-1] rate for New Hampshire Medicaid Members: *Chlamydia Screening in Women (CHL).*[1-2] A total of 27 people attended the four-hour virtual meeting. There were 17 participants from DHHS, the three MCOs, and provider groups. Ten additional people participated as speakers, facilitators, and HSAG support personnel.

The main objectives of the meeting included:

- Reach consensus concerning the barriers to chlamydia screening in female members
- Brainstorm potential DHHS, MCO, and provider strategies to address the barriers impacting the rates

The meeting began with a brief introduction from an HSAG staff member and three speakers from DHHS who shared information concerning the importance of sexual health to healthcare, an epidemiology update on the state of sexually transmitted diseases (STIs) in New Hampshire and nationally, and information concerning the HEDIS CHL screening rates for New Hampshire and by geography of county of residence. The Keynote Speaker then provided details concerning *Fighting the Chlamydia Epidemic: Why Screening is Sexy and How Systems Can Support it.* The final part of the meeting included facilitated brainstorming sessions to identify barriers to chlamydia screening and interventions to mitigate those barriers. Appendix A contains the meeting agenda.

This report includes information generated during the meeting through presentations and brainstorming sessions with the attendees. The ideas should not be assumed to be *statistically* representative of the organizations attending. They can be used, however, to identify salient issues relevant to the population, provide contextual information for the larger assessment process, and identify avenues for further investigation.

In this report, the words *member* and *patient* are used generically to denote Medicaid beneficiaries, MCO members, patients, and clients. The terms STIs and *sexually transmitted diseases* (STDs) are used interchangeably in the report to denote infections/diseases acquired during sexual contact.

[1-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[1-2] The HEDIS measure, *Chlamydia Screening in Women (CHL),* is defined by NCQA.

DHHS Speaker: Ann Goulbourne

The meeting began with Ann Goulbourne, RN, BSN, from the Bureau of Infectious Disease Control (BIDC), presenting information to confirm that sexual health is an important part of holistic health. Sexual health is defined as *a state of physical, mental, and social well-being, in relation to sexuality*.[2-1] Ms. Goulbourne also presented information concerning sexual health from two additional organizations:

- The first was from the World Health Organization (WHO): *Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence*.[2-2] WHO also acknowledged that the definition of sexual health also may differ around the world depending on the social and economic development of the communities and countries.
- The second was from the American Sexual Health Organization (ASHA): *Being sexually healthy means:*
  - *Understanding sexuality as a natural part of life involving more than sexual behavior*
  - *Recognizing and respecting the sexual rights we all share;*
  - *Having access to sexual health information, education, and care;*
  - *Making an effort to prevent unintended pregnancies and STDs and seek care and treatment when needed;*
  - *Being able to experience sexual pleasure, satisfaction, and intimacy when desired; and*
  - *Being able to communicate about sexual health with other including sexual partners and healthcare providers.*[2-3]

During the presentation, Ms. Goulbourne encouraged practitioners to include sexual histories as a routine part of physical health histories. Routine sexual health screenings should include:

- Addressing socioeconomic factors
- Discussing vaccines such as Hepatitis A (HAV), Hepatitis B (HBV), and Human Papillomavirus (HPV)
- Counseling and providing information concerning risk-reduction

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[2-1] Centers for Disease Control and Prevention. (2019). Sexual Health. Available at: https://www.cdc.gov/sexualhealth/default.html#who. Accessed on: June 26, 2023.

[2-2] World Health Organization. (2023). Sexual and Reproductive Health and research (SRH). Available at: https://www.who.int/teams/sexual-and-reproductive-health-and-research-(srh)/areas-of-work/sexual-health#:~:text=WHO%20defines%20sexual%20health%20as,of%20disease%2C%20dysfunction%20or%20infirmity. Accessed on: June 26, 2023.

[2-3] American Sexual Health Organization. (2022). What is Sexual Health? Available at: https://www.ashasexualhealth.org/sexual-health/. Accessed on June 26, 2023.

- Human Immunodeficiency Virus (HIV) prevention medication for those at risk for HIV
- Screen at all sites for STIs
- Inform the patient of the importance of expedited partner therapy (EPT)

Sexual histories may indicate psychiatric and/or other medical disorders, current health problems related to abuse, violence, or prior STDs; and the need for information concerning primary prevention from STIs to include immunizations, contraception, and medications for HIV.

Sexual health is a part of a holistic view of health and wellbeing, and includes understanding, access to information, prevention, care, and treatment. Sexual health histories should be a component of all health histories to effectively guide patient assessments.

Ms. Goulbourne presented closing remarks to stress why screening for chlamydia is important: It is the most frequently reported bacterial STI in the United States and is often asymptomatic. Chlamydia can cause infertility, ectopic pregnancy, and pelvic inflammatory disease (PID). Complications from PID affects female reproductive organs and can cause ectopic pregnancy, tubal infertility, and long-term pelvic pain. There is, however, highly effective preventive measure for PID: Screening all sexually active women for chlamydia.

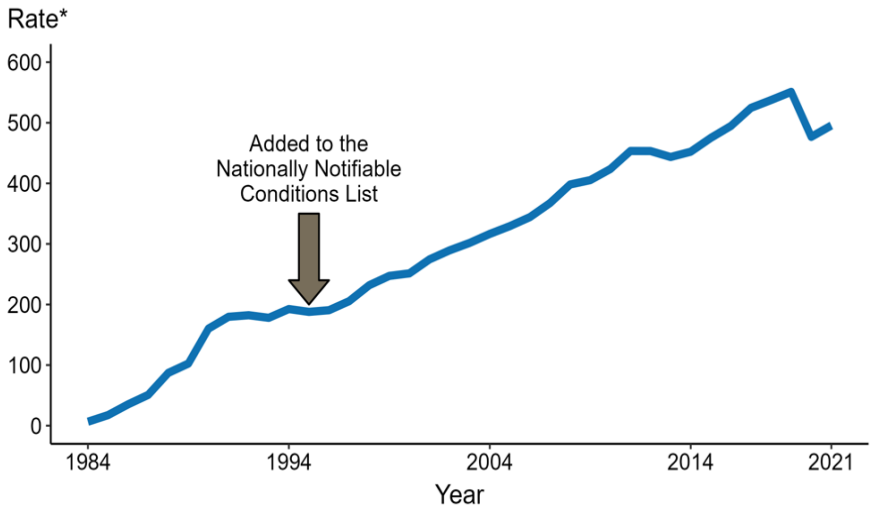
DHHS Speaker: Mariko Geiger

The second speaker from DHHS was Mariko Geiger, MS, MPH, Epidemiologist, from the BIDC. Ms. Geiger's topic included an STI epidemiology update with information from the Centers for Disease Control and Prevention (CDC) presentation, *Sexually Transmitted Disease Surveillance 2021*.[2-4]

Typically, if patients are not being screened for chlamydia, they are not being screened for any other STI. In 2021, there were 1.6 million cases of chlamydia in the United States. Figure 2-1 displays the rates of reported cases of chlamydia from 1984–2021, with the epidemic continuing to escalate in 2021. The CDC and the State of New Hampshire, however, want to urge caution in interpreting the data from 2020 and 2021, since reporting and routine visits have changed in the last two years. It is unclear how rates may be affected by those changes.

[2-4] Centers for Disease Control and Prevention. (2021). Sexually Transmitted Disease Surveillance 2021. National Center for HIV, Viral Hepatitis, STD, and TB Prevention—Division of STD Prevention. Available at: 2021-STD-Surveillance-All-Slides.pptx (live.com). Accessed on: May 25, 2023.

Figure 2-1—Reported Chlamydia Cases by Year in the United States from 1984–2021



Although there was a decrease of 228,818 cases during the coronavirus disease 2019 (COVID-19) in 2020 from the rate in 2019, the cases were beginning to close that gap in 2021. It is unclear if there is a true decrease in new infections or reflects changes in screening practices and access that may have occurred during the COVID pandemic. When comparing chlamydia cases by sex, there is a drastically higher rate for women than for men. This may be contributed to a higher biological risk in women, particularly young women. As mentioned in the presentation by Ms. Goulbourne, the consequences of chlamydia infection are also much greater for women than men.

Ms. Geiger also presented rates for other STIs. Although the number of cases of gonorrhea and syphilis continued to increase during the COVID pandemic of 2020they did so at a slower rate than pre-pandemic.

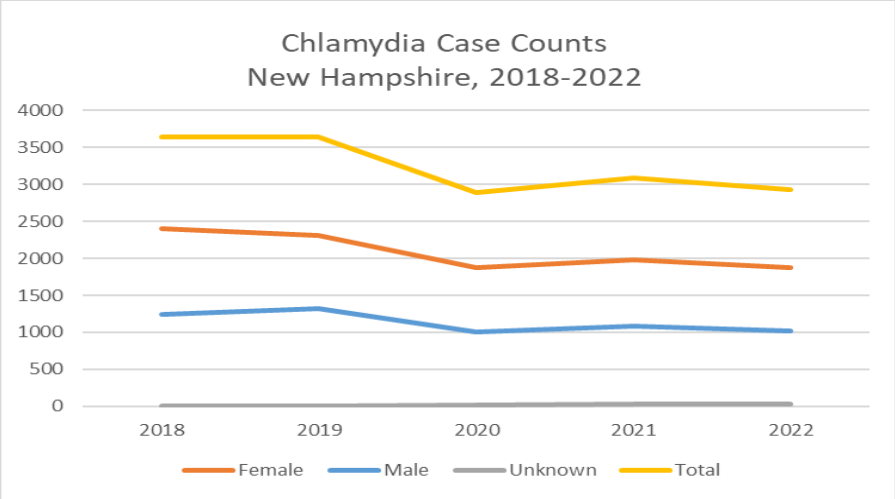
The rates of gonorrhea and syphilis in men are much higher than for women, however, the gap between the two sexes for syphilis appears to be closing.

Nationally, the number of cases of children born with congenital syphilis also continues to rise which appears to be associated with the increasing number of child-bearing age women (i.e., 15-44 years) with primary and secondary syphilis.

New Hampshire reported 2,924 cases of chlamydia in 2022.[2-5] Figure 2-2 illustrates the reported rates of chlamydia in New Hampshire from 2018–2022 by gender.[2-6]

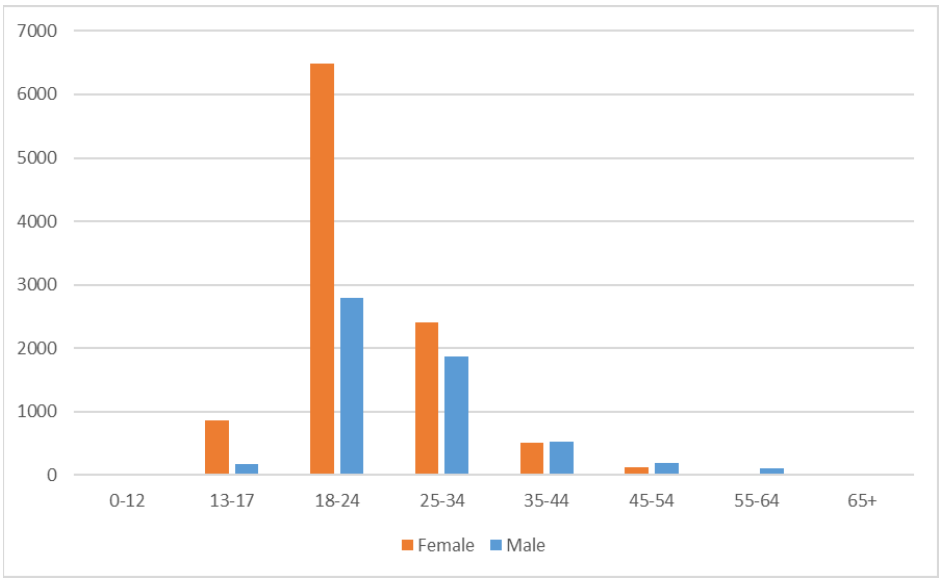
[2-5] New Hampshire Department of Health and Human Services, PRISM data. (2023).
[2-6] Ibid.

Figure 2-2—New Hampshire Chlamydia Rates by Gender at Birth From 2018–2022.



As with national data, females and young people are generating the highest number of reported cases of chlamydia. Figure 2-3 confirms that most reported cases are in women ages 18–24. That is also the age range for the highest reported rate of chlamydia in men. It is also interesting to note that the percentage decrease in the reported rate for males 18–24 years of age to males 25–34 years of age is less than in women.

Figure 2-3—New Hampshire Chlamydia Rates by Age and Sex from 2018–2022



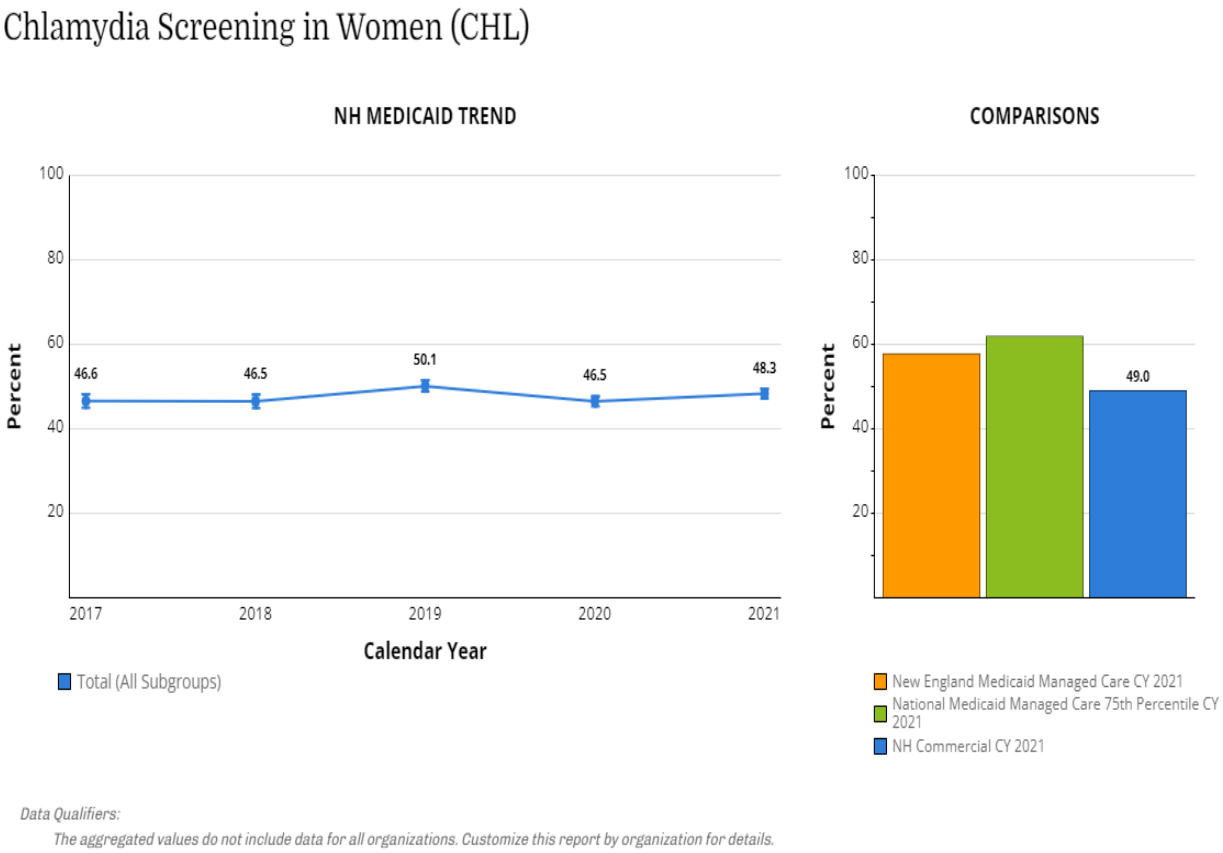
In closing, Ms. Geiger indicated that in New Hampshire, private physicians' offices (medical doctors [MDs] and doctors of osteopathic medicine [DOs]) diagnose most chlamydia cases. In the United States, chlamydia remains the most common notifiable STI with the highest rates among women, adolescents, and young adults. Decreases experienced in chlamydia rates over the last two years were unlikely due to

a reduction in new infections and more likely reflect changes in screening practices and access to care, especially during the public health emergency.[2-7]

DHHS Speaker: Erin Metcalf

The third DHHS staff member to present at the meeting, Erin Metcalf, MPH, from the Bureau of Program Quality, focused on the results of the HEDIS measure, *Chlamydia Screening in Women*, generated by the three Medicaid MCOs in New Hampshire. The results for the number of women screened beginning with calendar year (CY) 2017 are shown in the Figure 2-4.

Figure 2-4—Chlamydia Screening in Women (CHL) Receiving Healthcare from the New Hampshire Medicaid MCOs: Total Rate 2017–2021 [2-8]



2-7 Ibid.

2-8 New Hampshire Medicaid Quality Reporting. (2022). Chlamydia Screening in Women (CHL).

The CHL rate shown for CY 2021 was 48.3 percent and included a numerator of 4,181 and a denominator of 8,655. The goal for the measure is the National Medicaid Managed Care 75th Percentile rate that is displayed by the green bar to the right of the figure.

The description of the measure includes the percentage of women 16–24 years of age enrolled during the measurement year with no longer than a 45-day gap in enrollment. The rate included women who were identified as sexually active and had at least one test for chlamydia during the measurement year. Sexually active is defined by:

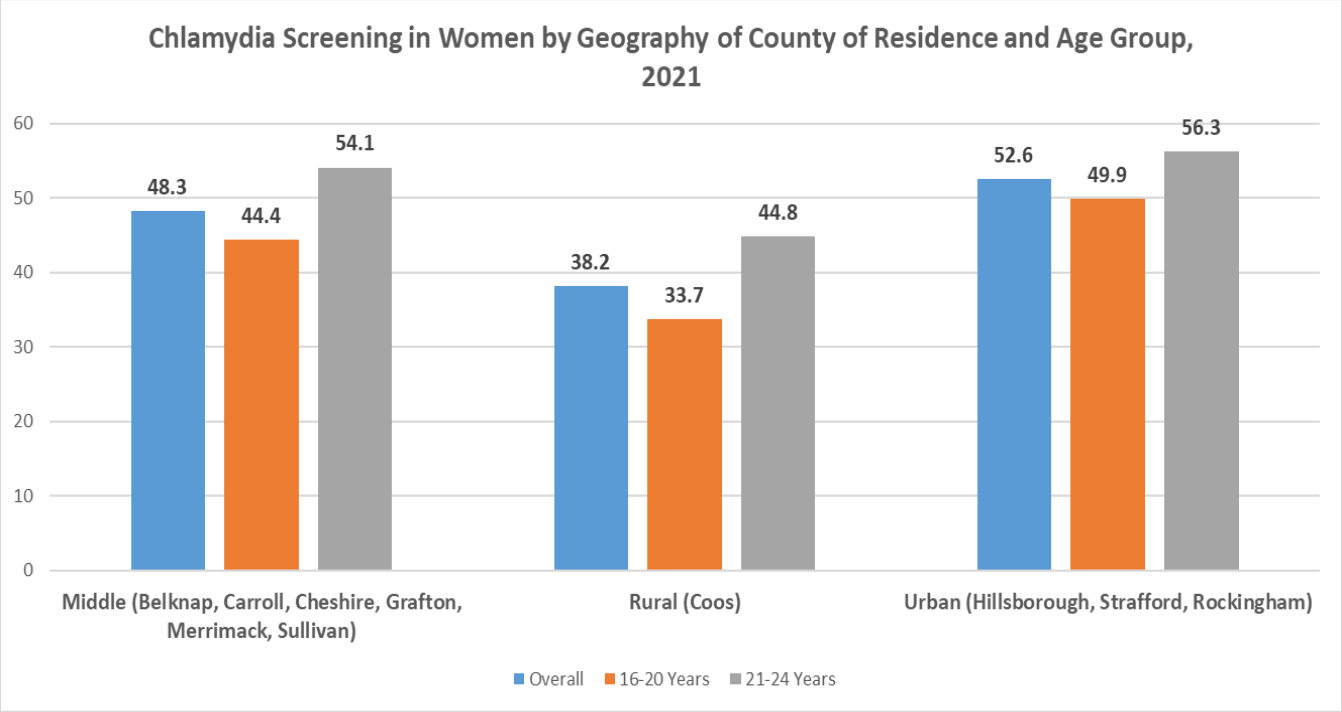
- Claims/encounters data – pregnancy value set, sexually activity value set, pregnancy test value set codes during the measurement year, or;
- Pharmacy data: Members dispensed prescription contraceptives during the measurement year. Pharmacy data includes contraceptives, diaphragm, or spermicide.

The measure has two indicators:

- Members 16–20 years
- Members 21–24 years

Ms. Metcalf presented the chlamydia screening rates in New Hampshire by urban, middle, and rural counties as displayed in Figure 2-5.

Figure 2-5—Chlamydia Screening in Women (CHL)



The information displayed in Figure 2-5 confirms that women in the 21–24 years age group received chlamydia screening more frequently than the women in the 16–20 age group. The county of residence also contributed to the frequency of testing by confirming that women living in rural Coos county were less likely to receive chlamydia screening than those living in the middle or urban counties of the State.

DHHS identified limitations associated with the HEDIS CHL measure, and those limitations include:

- Only evaluating tests given to women
- Only evaluating younger age categories
- Not capturing women who use long-term forms of birth control (i.e., intrauterine devices [IUDs], etc.)
- Not capturing women using non-prescription forms of birth control (i.e., condoms, some IUDs, etc.) or no birth control.

In closing, Ms. Metcalf reviewed the 2021 New Hampshire CHL rate of 48.3 percent and noted that the State's rate has been consistent. The rate, however, has been consistently below the National Medicaid Managed Care 25th Percentile.

Polling Question

After Ms. Metcalf's presentation, HASG requested each participant to respond to a polling question to determine the type of organizations represented at the meeting. Table 2-1 displays the results of the poll. Although 27 participants logged into the meeting at various times during the four-hour presentation, only 17 participants responded to the polling question. The additional 10 people could have been the speakers, facilitators, and HSAG support personnel as previously mentioned.

Table 2-1—Polling Question: Organizations Represented at the Meeting

Type of Organization	Number Responding to Polling Question
Obstetrics/Gynecology or Primary Care Provider Office Staff Member	4
DHHS	7
MCO	6
TOTAL	**17**

3. Keynote Speaker: Katherine Hsu, MD

The keynote speaker, Katherine Hsu, MD, MPH, FAAP introduced the topic of the presentation: *Fighting the Chlamydia Epidemic: Why Screening Is Sexy and How Systems Can Support It*. Dr. Hsu is the Director of the Ratelle STD/HIV Prevention Training Center; Medical Director, Division of STD Prevention & HIV/Acquired Immunodeficiency Syndrome (AIDS) Surveillance, Massachusetts Department of Public Health; and Professor of Pediatrics, at Boston University Medical Center.

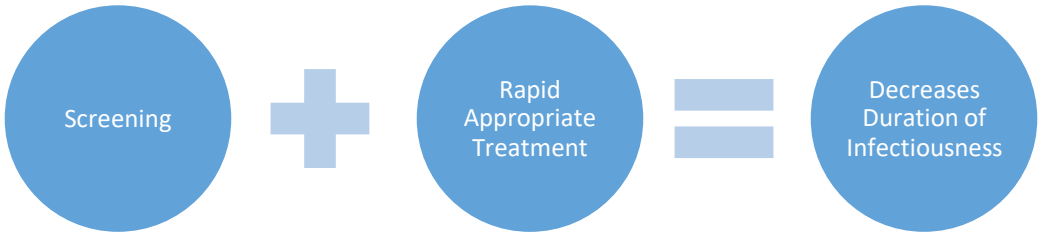
Dr. Hsu informed attendees that she practices primary care one afternoon each week at an adolescent center at the Boston University Medical Center. This activity provides an ongoing perspective of caring for the patient along with the broader, population health perspective required by her other positions. As a practicing physician, Dr. Hsu noted that currently practitioners must remember to screen patients for STDs, which triggered the question posed at the beginning of her presentation: "*How can we more effectively use systems to automate processes to ensure screening?"*

The outline of the presentation included three significant topics:

- Why screening works to decrease the burden of infection on a population level;
- Why treatment of patients will not succeed if infected partners are not treated; and
- How repeat screening of previously infected individuals reaches those at highest risk of infection.

As demonstrated in studies during the HIV epidemic, the basic reproductive rate of a disease increases due to three factors: Transmissibility, number of sexual contacts, and the duration of infectiousness. An example of interfering with transmissibility is to develop effective vaccines to combat the virus (i.e., HIV, Hepatitis B, etc.). Unfortunately, that is not a tool we currently have since none has been developed to prevent chlamydia. Without having an effective vaccine, we are left with two solutions: Decreasing the number of sexual partners of infected individuals or decreasing the duration of infectiousness. It is very difficult to interfere with the number of sexual partners, so we must focus on the duration of infectiousness.

Screening someone and rapidly treating them appropriately and correctly with the right drug regimen achieves the best way to eradicate microbial carriage. Interfering with carriage interferes with transmission.



A study conducted on the prevention of PID by Delia Scholes et. al. in 1996 demonstrated a clear difference between patients who were screened for chlamydia verses those who were not screened.[3-1] Over the course of a year, those who were screened demonstrated a 56% reduction in the incidence of PID in a managed care setting.

Our greatest struggle continues to be implementing the process to ensure that all patients receive chlamydia screening. It is very difficult to test every person who deserves to be screened for chlamydia. Mary Ann Schaefer et. al. at Kaiser Permanente, however, found a solution to the problem of screening adolescent girls for chlamydia in 2002.[3-2]

> "All participating sites decided that the most effective way to ensure confidential collection of urine and C. trachomatis screening during checkups was to institute universal urine specimen collection from all adolescents at registration, prior to their examination."

Shafer et al., *JAMA* 2002

Two more issues associated with chlamydia transmission involve the fact that the infectiousness/ reservoir has not been accurately defined, and transmission has been attributed largely to asymptomatic carriers. Dr. Hsu presented one theory concerning chlamydia: The chlamydia trachomatis organism may be able to evade gastric acid and transit the organism to the lower gastrointestinal track during oral intercourse. Studies have demonstrated that a high percentage of women attending routine clinics who tested positive for urogenital chlamydia from a urine specimen or vaginal samples also were co-colonized at the rectal site.

Chlamydia treatment recommendations in 2015 involved prescribing a single dose of one gram of azithromycin. Current chlamydia treatment recommendations, however, involve prescribing 100 milligrams of doxycycline twice a day for seven days. Doxycycline has proven in multiple studies to be more effective in treating rectal chlamydia for men and women than treatment with azithromycin. Even if there are concerns that a patient may not complete the seven-day course of doxycycline, it should still be the recommended therapy. Clinicians should be aware of the finding that neither azithromycin nor

3-1 Scholes D, Stergachis A, Heidrich FE, Andrilla H, Holmes, KK, and Stamm WE. Prevention of Pelvic Inflammatory Disease by Screening for Cervical Chlamydial Infection. *The New England Journal of Medicine. 1996;*1362.

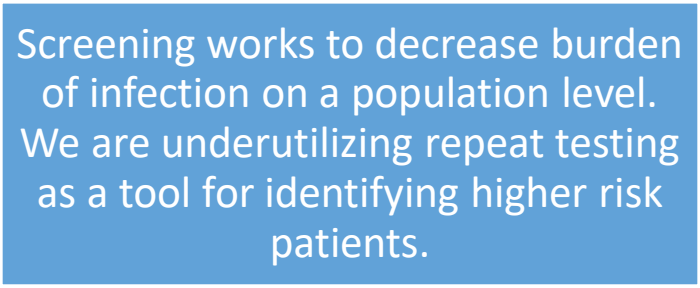
3-2 Shafer MA, Tebb, KP, Pantell RH, Wibbelsman CJ, Neuhaus JM, Tipton AC, Kunin SB, Ko TH, Schweppe DM, and Bergman DA. Effect of a Clinical Practice Improvement Intervention on Chlamydial Screening Among Adolescent Girls. *Journal of the American Medical Association.* 2022; 288; 22.

doxycycline are extremely well tolerated by some patients and clinicians should be prepared to prescribe an anti-nausea medication.

Treating chlamydia in pregnancy is very important to eliminate the possibility of transmission to an unborn infant. The first line therapy is a single-dose azithromycin because of a hesitation to use doxycycline during pregnancy. Clinicians need to test the pregnant women after the single-dose therapy to ensure that the patient does not test positive again for chlamydia, especially around the time of delivery.

EPT is also important to minimize the risk of re-infection for patients testing positive for chlamydia. New Hampshire allows the dispensing of medication for the patient's partners through the patient or through partnering pharmacies without examining the partner. Whenever possible, however, EPT should be provided a drug-in-hand therapy.

Clinical interventions and effective treatment of chlamydia can improve the management of the STIs. The scope of the problem is not the entire population, but, in effect, a smaller circulating sexual network. Core groups are our key for systems to focus on to improve sexual health.



In summary, improving the rate of chlamydia screening involves the following:

- Automatically screening patients younger than 25 years of age. Combined with appropriate treatment, it decreases carriage of transmissible infection.
- Additional administrative support to implement effective EPT. This is difficult to implement and needs more administrative support.
- A systems approach to recall patients for test-of-reinfection to reach those at high-risk of infection. Repeat screening of previously infected individuals reaches those as highest risk of infection.

This powerful presentation set the stage for the ensuing discussions about barriers to care and the strategies to overcome the barriers for chlamydia screening in New Hampshire.

4. Barrier Evaluation

After the presentations by the speakers, the annual quality meeting included a brainstorming session for participants to identify and prioritize the barriers to improving chlamydia screening in New Hampshire. The facilitator, Tanya Lord, PhD, led the participants through the activity using the MURAL application, which provided a visual, real-time collaboration of ideas. Carrie McFadden, MPH, also assisted Dr. Lord in facilitating the brainstorming sessions. Prior to the meeting, Dr. Lord and Ms. McFadden offered two training sessions for participants to learn about the MURAL application on the afternoon of May 17, 2023, and the morning of May 18, 2023. A total of 23 participants attended the two MURAL training sessions.

The MURAL application allowed participants to write ideas on "sticky notes" and post them to a community whiteboard. Dr. Lord encouraged all attendees to participate in contributing ideas to the exercise. The first activity identified barriers to chlamydia screening by the participants, and the facilitators grouped the responses into nine categories. The list below includes the nine categories and the number of responses for each category:

- Education (17)
- Comfort discussing STIs (14)
- Screening (8)
- Access to care (8)
- Time constraints (6)
- Follow-up issues (4)
- Partner Follow-up (3)
- System issues (2)
- Staffing issues (2)

The facilitator then briefly discussed the categories provided by the participants, and the participants voted to select the three top barriers from the nine categories. To ensure that the voting represented the different type of organizations represented at the meeting, voting was restricted to one person from DHHS and the MCOs. After the facilitators counted the votes, the top barriers included three predominate themes:

- Education
- Comfort discussing STIs
- Screening

The next sections of the report provide additional information concerning the three top three barriers.

Education

Participants recognized that a lack of comprehensive education concerning chlamydia and other STIs presented a significant barrier to effective screening. Insufficient knowledge about the risks, symptoms, and long-term consequences of chlamydia also prevented patients from requesting timely screening and treatment.

The participants generated 17 comments about barriers to chlamydia screening due to education, and those comments generated four categories of responses:

- Lack of awareness of importance of screening even if patient is asymptomatic and appears at low risk (n=8)
- Lack of knowledge about chlamydia screening: Process is not normalized; who is responsible to screen; the long-term effects of chlamydia; and the importance of rescreening (n=7)
- Systems and processes are not designed to support screenings and re-screenings (n=1)
- Topics and attitudes concerning sexual health education have been politicized (n=1)

The greatest concern expressed for education in eight comments was a general lack of awareness by the provider and the patient of the importance of screening, especially if the patient appears to be at low risk and is asymptomatic. Participants noted providers should screen appropriately aged patients at every visit. Providers also need to ensure that patients receive information concerning the long-term effects of chlamydia and the importance of re-screening. Programming automated system reminders, developing processes concerning chlamydia screening, and the politicizing of the topic of STIs completed the barriers to providing education to patients.

Comfort Discussing STIs

The participants identified the discomfort and stigma associated with discussing STIs as a significant barrier. Many individuals, including clinicians, feel uncomfortable when discussing matters of sexual health, which presents a challenge to having open conversations with patients concerning appropriate screening services. Participants identified addressing the stigma and promoting a non-judgmental and supportive environment as crucial for increasing screening rates.

The comfort of discussing STIs by patients and providers generated 14 comments about those barriers in three categories of responses:

- Provider and patient discomfort discussing sexual issues (n=8)
- Patient confidentiality issues; minors not wanting to discuss with parents present or afraid parents will know about their sexual activity (n=3)
- Stigma and normalizing discussions concerning sexual activity (n=3)

The greatest concern expressed in eight responses was the overall discomfort by providers and patients concerning discussions about sexual health. Confusion over patient confidentiality and the stigma associated with discussions of sexual activity generated six responses.

Increase Chlamydia Screening

This barrier is very closely associated with the question posed at the beginning of the presentation by Dr. Hsu: "*How can we more effectively use systems to automate processes to ensure screening?"* The participants discussed the many challenges associated with ensuring that every appropriately aged patient is screened for chlamydia at every visit without automated reminders to both the provider and the patient.

Participants submitted eight comments concerning ways to increase chlamydia screening, and those comments generated three categories of responses:

- Protocols and systems not developed to routinely screen for chlamydia during all visits (n=6)
- Issues associated with collecting samples off-site (n=1)
- Legal risks associated with screening a patient who is not assigned to the provider and does not routinely visit the provider (n=1)

Most comments about barriers to screening concerned not having established protocols and system reminders to support routine screenings for chlamydia. Barriers also exist in ensuring that patients visit off-site laboratories when a chlamydia test is ordered. The final barrier to increase chlamydia screening noted challenges associated with screening a patient who is not assigned to the provider and does not routinely visit the provider.

Appendix B includes detailed responses concerning the barriers identified by the participants.

Strategies to Address Barriers

After the brainstorming session identified the top three barriers, the facilitator initiated the final session of the meeting to identify strategies to overcome those barriers. Once again, the facilitator led the group through the activity using the MURAL application. Participants could vote for one to three strategies to address the barriers identified in the previous activity, and again voting was restricted to one person from DHHS and one person from each MCO. The facilitator counted the votes and identified the top categories of strategies to address the barriers. The number of votes for each strategy is included in the information listed below.

Education

The participants suggested six strategies to improve education concerning chlamydia for DHHS, MCOs, and providers as shown below. Participants identified three strategies for DHHS, two for the MCOs, and one for providers. There were seven votes for the six educational strategies.

DHHS

The participants identified three strategies for consideration by DHHS to overcome the barriers to education:

- Understand how people access information and develop campaigns to meet people where they are (2)
- Start at the top: (Develop)[5-1] educational systems to (give) providers (for) awareness campaigns (1)
- Public service campaigns (1)

MCOs

The participants identified two strategies for consideration by the MCOs to overcome the barriers to education:

- Furnish data to providers (concerning) their (screening) rates (1)
- (Furnish) provider education related to the importance of routine screenings including follow-up screenings for high-risk patients (1)

[5-1] Words in parenthesis have been added for clarity.

Providers

The participants identified one strategy for consideration by providers to overcome the barriers to education:

- Provide educational material (i.e., handouts, pamphlets, etc.), especially in areas of the office where patients are alone (e.g., restrooms) (1)

Comfort Discussing STIs

The participants suggested four strategies to improve the comfort in discussing STIs for DHHS and providers as shown below. Participants identified three strategies for DHHS, one for providers, and none for the MCOs. There were eight votes for the four educational strategies.

DHHS

- Develop public awareness campaigns (3)
- Involve school nurses in promotions (2)
- Normalize sexual health into routine healthcare (2)

Providers

- Integrate sexual health conversations into all health conversations (1)

Increase Chlamydia Screening

The participants suggested nine strategies to increase chlamydia screening for DHHS, MCOs, providers, and individuals seeking care as shown below. Participants identified three strategies for DHHS, three for the MCOs, two for providers, and one for patients. There were 14 votes for the strategies to increase chlamydia screening, a much greater number of votes than for either of the previous two barriers.

DHHS

- Automate screening, reminders for provider electronic medical records and patient portals (1)
- Develop protocols for pharmacy dispensing treatment of patients and partners (1)
- Look at high performing states for lessons learned (1)

MCOs

- Create a standard practice for screening based on the information from Youth Risk Behavior Survey (YRBS) data (3)
- Assure that STI screening and treatment are covered as no-cost services (1)
- Promote and reinforce routine screening as a normal practice (1)

Providers

- Implement universal screening protocols (2)
- Create protocols for the treatment of STI infections for patients and partners (2)

Patients

- Allow opt-out screening for adolescents and emerging adults (2)

Appendix C contains a complete list of the strategies to address the barriers.

6. Conclusions

The meeting concluded with a presentation by Ann Goulbourne concerning *The Role of the Linkage to Care Team at the Bureau of Infectious Disease Control (BIDC).* Ms. Goulbourne emphasized the support available to all providers to educate patients about the importance of screening and to ensure adequate treatment for patients with reportable STIs. The New Hampshire Division of Public Health Services will assist with interviewing individuals diagnosed with STIs, provider patient education, encourage self-advocacy, and emphasize the importance of testing, treatment, and EPT.

As noted by the participants in the meeting, sexual health should be normalized and integrated into all health histories and routine care. Normalizing age-based gender-blind screening could identify high-risk individuals. Ms. Goulbourne also noted the importance of identifying barriers related to socioeconomic factors and health disparities. To improve the rates of chlamydia screening in New Hampshire, it is essential for public health, healthcare providers, clinicians, educators, and the State and federal government to work together in disseminating educational material and developing systems and processes to normalize the discussion of sexual health. Informing the public that chlamydia, although often asymptomatic, is the most frequently reported bacterial STI in the United Stated is important since chlamydia can cause long-term health issues including infertility, ectopic pregnancy, and PID.

At the conclusion of Ms. Goulbourne's presentation, Erin Metcalf offered closing remarks and thanked the presenters and participants for attending the meeting. She also reminded participants to complete the survey evaluation form that will be sent to everyone.

After the meeting, 16 participants completed evaluation forms. Six items required a *Strongly Agree*, *Agree*, *Disagree*, or *Strongly Disagree* response. All but one response was *Strongly Agree* or *Agree*. Appendix D contains the meeting evaluation form.

The number of participants attending the meeting, the number of participants who attended the MURAL training sessions prior to the meeting, the diversity of organizations represented, the information presented by the speakers, the guidance provided by the facilitators, and the feedback generated during the meeting attest to the success of the virtual New Hampshire Annual Quality Meeting concerning improving the rates of chlamydia screening in New Hampshire.

Appendix A. Agenda

DHHS Roundtable

Increasing Medicaid Member Chlamydia Screening Rates

Agenda

Tuesday, May 23, 2023

Objectives

- Objective #1—Reach consensus concerning the barriers to chlamydia screening in female members
- Objective #2—Brainstorm potential DHHS and MCO support for addressing the barriers that are impacting NH's rates

Time	Agenda Item	Speaker/Presenter
8:30 am	Welcome & Logistics	HSAG
8:35 am	Intro – Outline of the Day	HSAG
8:40 am	Sexual Health is Important to Healthcare Epi Update	Ann Goulbourne, RN, BSN and Mariko Geiger, MS, MPH Bureau of Infectious Disease Control
9:00 am	CHL Rates and Measure – • Explain HEDIS Measure & Limitations • NH Medicaid CHL data • Screening Rates	Erin Metcalf, MPH Bureau of Program Quality
9:20 am	Keynote Speaker "Fighting the Chlamydia Epidemic: Why Screening is Sexy and How Systems Can Support It."	Katherine Hsu, MD, MPH Medical Director, Division of STD Prevention & HIV/AIDS Surveillance, Massachusetts Department of Public Health
9:45 am	Facilitated Discussion on Brainstorming Barriers • Structured feedback from different groups versus opening up the floor for anyone to talk. • Potential Barriers – group voting	Tanya Lord, Ph.D.

Time	Agenda Item	Speaker/Presenter
10:45 am	Break	
11:00 am	Facilitated Discussion on Brainstorming Solutions	Tanya Lord, Ph.D.
11:50 am	Facilitator Discussion – Summary of Brainstorm Exercise • Potential Solutions: What can be done – group voting Next Steps	Tanya Lord, Ph.D.
12:15 pm	The role of a Sexual Health Nurse Specialist & the Bureau of Infectious Disease Control	Ann Goulbourne, RN, BSN
12:30 pm	Closing Remarks	Erin Metcalf, MPH

Appendix B. Barriers

Barriers Sorted by Themes[B-1]	
Education (17)	
1	Process is not normalized
2	Topics of sexual health education have been politicized
3	Lack of knowledge
4	Assuming patient is not sexually active
5	Provider perceives patient is low risk
6	Lack of patient education; thinking they are not at risk
7	Lack of understanding of what makes someone "at risk"
8	Lack of awareness of importance to be screened
9	Who is responsible? Do we know?
10	Lack of tracking/recall
11	Lack of awareness of high prevalence of STDs
12	Patient may be asymptomatic and not seek care
13	Rescreening: Lack of patient and provider knowledge
14	Lack of awareness: Providers and public
15	Lack of patient awareness and education at early ages
16	Education is needed about risks and long-term impacts on health
17	Awareness: Providers and public

B-1 The facilitators prepared the table containing the *Barriers Sorted by Themes* after reviewing the participant responses during the meeting.

Barriers Sorted by Themes[B-1]	
Comfort Discussing STIs (14)	
1	Provider not comfortable discussing STI screening
2	Concerns related to confidentiality
3	Sensitivity of conversation
4	Stigma related to discussion on sexual health concerns
5	Discomfort discussing sexual health history
6	Provider discomfort with discussing sexual activity
7	Discomfort in general around discussing sexual health
8	Patients not comfortable discussing their sexual activity
9	Patient and provider uncomfortable discussing sexuality/risks
10	Fear of stigma
11	Patients not feeling comfortable with the discussion topic
12	The discussion is not normalized
13	Minors not wanting to discuss sexual history with parent present
14	Patient confidentiality: Don’t want parents to know
Screening (8)	
1	Protocols not in place for clinics to routinely screen
2	Not being addressed during acute non-related visits
3	Ability to include discussion in flow of office visit
4	Routine sexual health histories for all seeking care—need to implement
5	Sexual histories are not routinely part of well care in PCP offices
6	Lack of automation; leaving it up to individual providers

Barriers Sorted by Themes[B-1]	
7	Collecting off-site samples
8	STI workflow, providers caring for a non-patient and legal risks
Access to Care (8)	
1	Young women not routinely seeking well care
2	Access to and value of preventive care
3	Access to care
4	Access
5	Topics of sexual health have been politicized
6	Patient access to care
7	Access to care; knowledge of resources
8	Not seeing young adults annually for physicals
Time Constraints (6)	
1	Competing priorities during short office visits
2	Time and resource constraints
3	Time
4	Priorities
5	Lack of time to screen
6	Competing demands
Follow-Up Issues (4)	
1	Follow-up after initial screening/treatment
2	Patient follow-up
3	Patient not returning for TOC (test of cure)
4	Need electronic medical records to facilitate reminders/pop-ups

Barriers Sorted by Themes[B-1]	
Partner Follow-Up (3)	
1	Electronic medical record and STIs: Cannot create prescription for partner therapy without a patient chart
2	Barriers to expedited partner therapy
3	Ability to treat partners
System Issues (2)	
1	Internal system champions needed
2	Cost concerns
Staffing Issues (2)	
1	Staffing/ability to carry-out follow-up
2	Staffing needs

Appendix C. Strategies to Address Barriers

Strategies to Address Barriers[C-1]
Education
Strategies for DHHS
Understand how people access information and develop campaigns that meet people where they are
Start at the top: (Develop)[C-2] educational systems to (give) provider (for) awareness campaigns
Public Service Campaign
Start early education
Make sure providers/public know their resources
It is everyone's responsibility: No siloing
Improve access to education in the schools
Work with other DHHS departments and partners
Provide education via provider outreach within DHHS IDC (Infectious Disease Control)
DHHS (could) attend professional association meetings to educate
Wider net for education to reach more people at the same time
Partner with colleges' health programs
Educate providers on how to talk to patients about sexual health
Create DHHS as a resource for STI information and support
Promote April as STD Awareness Month
Strategies for MCOs
Furnish data to providers (concerning) their (screening) rates

C-1 The facilitator prepared the table concerning the *Barriers Sorted by Themes* after reviewing the participant responses during the meeting.

C-2 Words in parenthesis have been added for clarity.

Strategies to Address Barriers[C-1]
(Furnish) provider education related to routine screenings including follow-up screenings for high-risk patients
Speak to those who determine content of patient and provider newsletters
Member information related to routine visits and recommended screening
Utilize provider portals
Partner with community agencies' public programs with educational opportunities
Information in the provider newsletter
Information in the member newsletter
Utilize patient portals
Strategies for Providers
Provide educational handouts, pamphlets, etc., especially in areas where the patients are alone (e.g., restrooms)
Educational handouts, pamphlets, etc.
Discuss with patients: Screening is a normal part of sexual health
Strategies for Patients Seeking Care
Access to trusted, accurate information
In-office pamphlets and flyers
Electronic medical records prompting to test
Comfort Discussing STIs
Strategies for DHHS
Develop Public Awareness Campaign
Involve school nurses in promotion
Normalize sexual health into routine healthcare
Providers can set the tone; perhaps start with a patient questionnaire and then focus on concerns during the visit

Strategies to Address Barriers[C-1]
Have voices of those impacted at the table to support solutions in reducing stigma
Educational efforts will help with this barrier as well
Include sexual health messaging in other broader campaigns about general wellness
Strategies for MCOs
Write the educational content in the member newsletter in a manner that normalizes the topic and encourages discussion
Routine messaging aligned to public messaging
Solicit feedback from members in member group sessions
Strategies for Providers
Integrate sexual health conversations into all health conversations
New York City Health Department has excellent resources to share
Allow for private opportunities to discuss issues of sexual health and screening
Change forms that makes language non-judgmental
Participate in education
Participate in early education
Welcoming and inclusive waiting rooms with information about sexual health easily accessible
Strategies for Patients or Individuals Seeking Care
Allow information to be collected that enhances privacy (i.e., I-pads, surveys, etc.)
Screening
Strategies for DHHS
Automate screening, reminders for provider; electronic medical records and patient portals
Develop protocols for pharmacy dispensing treatment of patients and partners
Look at high-performing states for lessons learned
Improve system for reporting infections to minimize burden on providers/staff

Strategies to Address Barriers[C-1]
Promote increased awareness of high burden of STDs
Promote standing orders for testing in provider offices
Strategies for MCOs
Create standard practice for screening from the Youth Risk Behavior Survey data; age based and gender non-specific
Assure that STI screening and treatment are covered no-cost services
Promote and reinforce routine screening (as) norm and expected
Reinforce confidentiality to patients
Offer provider incentives
Texting campaign to members in HEDIS measure denominator
Address the role unconscious bias may play
Strategies for Providers
Implement universal screening protocols
Protocolize treatment of STI infections for patients and partners
Identify (a) champion in the practice to take the lead on initiatives
Utilize electronic medical record reports to identify patients due for screening
Routine screening-standing orders
Automate collection
Change recommendations for routine visits for young adults
Utilize standing orders for screening
Create standard work for clinical staff
Strategies for Patients or Individuals Seeking Care
Adolescents and emerging adults prefer opt-out age-based screening
Collect specimen in provider office rather than have patient go to lab

Strategies to Address Barriers[C-1]
Increase routine age-based screening to people do not need to request or identify risk factors if discomfort is present

DHHS Roundtable
Increasing Medicaid Member Chlamydia Screening Rates
Evaluation Form
Tuesday, May 23, 2023

Please check the response that most accurately describes your evaluation of the following statements.

A. Objectives

The following objectives were met during the meeting:	Strongly Agree	Agree	Disagree	Strongly Disagree
1. Reach consensus on the barriers to Chlamydia screening in female members that are resulting in New Hampshire rates.				
2. Brainstorm potential DHHS and Managed Care Organization (MCO) support for addressing the barriers that are impacting NH's rates.				

B. Sexual Health is Important to Healthcare

The Role of a Sexual Health Nurse Specialist & The Bureau of Infectious Disease Control
Speaker: Ann Goulbourne, RN, BSN
NH DHHS, Bureau of Infectious Disease Control

	Strongly Agree	Agree	Disagree	Strongly Disagree
The speaker was knowledgeable about the topic of the meeting, an effective speaker, and presented valuable information regarding the importance of Chlamydia screening in females.				

C. Epidemiology Update

Speaker: Mariko Geiger, MS, MPH
NH DHHS, Bureau of Infectious Disease Control

	Strongly Agree	Agree	Disagree	Strongly Disagree
The speaker was knowledgeable about the topic of the meeting, an effective speaker, and presented valuable information regarding the importance of Chlamydia screening in females.				

D. Chlamydia Rates and Measure

Speaker: Erin Metcalf, MPH
NH DHHS, Bureau of Program Quality

	Strongly Agree	Agree	Disagree	Strongly Disagree
The speaker was knowledgeable about the topic of the meeting, an effective speaker, and presented valuable information regarding the importance of Chlamydia screening in females.				

E. Fighting the Chlamydia Epidemic: Why Screening is Sexy and How Systems Can Support It

Keynote Speaker: Katherine Hsu, MD, MPH
Medical Director, Division of STD Prevention & HIV/AIDS Surveillance
Massachusetts Department of Public Health

	Strongly Agree	Agree	Disagree	Strongly Disagree
The speaker was knowledgeable about the topic of the meeting, an effective speaker, and presented valuable information regarding the importance of Chlamydia screening in females.				

F. Meeting Facilitator

Tanya Lord, PhD
Chief Innovation Officer
ATW Health Solutions

	Strongly Agree	Agree	Disagree	Strongly Disagree
The facilitator effectively and efficiently managed the discussions during the meeting.				