
The Minnesota Chlamydia Strategy: Action Plan to Reduce and Prevent Chlamydia in Minnesota



April 2011



Protecting, maintaining and improving the health of all Minnesotans

April 12, 2011

To the readers of Minnesota's Chlamydia Strategy: Action Plan to Reduce and Prevent Chlamydia in Minnesota.

Chlamydia is an important public health issue in Minnesota with over 15,000 cases reported in 2010 and rates that have doubled over the past 10 years. Over the past year, a steering committee composed of community-based organizations, clinics, local public health, and Minnesota Department of Health staff worked magic to convene the first ever Minnesota Chlamydia Summit and created the Minnesota Chlamydia Partnership (MCP). The process enlisted and engaged over 300 community members who contributed to developing this Strategy.

We would like to acknowledge the dedication and hard work of both public health and community leadership over this very short time. We congratulate the MCP and look forward to working with the MCP to implement the Minnesota Chlamydia Strategy. It is also incumbent upon all Minnesotans to become aware of the chlamydia epidemic and contribute to combating chlamydia and all sexually transmitted diseases in our state.

As you read this document, carefully note the very important key issues related to Minnesota's chlamydia epidemic. The Strategy identifies the needs for information on healthy sexuality, expanded routine testing, increased funding, and increased public awareness.

This is about protecting the disenfranchised and vulnerable, especially Minnesota's young adult and adolescent populations. Read this strategy, identify what you can do, and then work with all of us to protect these populations.

A handwritten signature in black ink that reads "Kristen Ehresmann".

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A handwritten signature in blue ink that reads "Peter Carr".

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The Minnesota Chlamydia Strategy: Action Plan to Reduce and Prevent Chlamydia in Minnesota

Minnesota Chlamydia Partnership, April 2011

Executive Summary

Chlamydia is the most frequently reported sexually transmitted infection/disease (STI/STD) in Minnesota and the U.S. The *Minnesota Chlamydia Strategy: Action Plan for Reducing and Preventing Chlamydia in Minnesota* is the first comprehensive, statewide action plan to address the chlamydia epidemic to be developed in Minnesota. As rates of chlamydia continued to increase over time, federal funding for screening, testing and treatment remained flat or decreased, and state funds were non-existent. The STD and HIV Section of the Minnesota Department of Health recognized that impacting current chlamydia disease rates was beyond its scope and available resources. New partnerships from within, as well as outside the public health arena were needed so that innovative ideas and approaches, especially from the populations of youth most impacted by the epidemic could be explored. The need for an action plan was also identified. The Minnesota Chlamydia Partnership was formed in 2010 and this document is the result of over 300 individuals and several organizations from across Minnesota working together to create a common framework for action to reduce the burden of chlamydia in Minnesota.

A New Approach

The purpose of this Strategy is to inform the people of Minnesota about the epidemic of chlamydia, the factors that contribute to increases seen over the past 14 years, and the consequences of ignoring the state of health of our youth. It also provides suggestions and recommendations for actions that can be taken to improve the sexual health of young Minnesotans. These actions include suggestions for members of the medical community, including raising the awareness in medical providers of the need to screen more young women and their sexual partners and to assist the MDH in assuring that they are treated when positive for the infection.

However, chlamydia is more than a medical problem. The reasons why people engage in unprotected sex – the only route for transmitting a sexually transmitted infection or disease – are varied and complex. Consequently, our responses must be multi-faceted and well-conceived. We hope that this Strategy will stimulate conversations in many groups across Minnesota as they discuss how they can make a difference in this important issue. Any person in Minnesota who cares about young people and issues of health can become involved in helping to find solutions.

Vision of the Minnesota Chlamydia Partnership and Strategy

Members of the Steering Committee for the Minnesota Chlamydia Partnership designed a vision that includes the following overarching, long-term outcomes:

- Reduce rates of chlamydia and gonorrhea in Minnesota, especially in people ages 15-25;
- Increase awareness of chlamydia in the general public;
- Change the behavior of adolescents so that they are reducing their risk for contracting and transmitting diseases;
- Reduce the stigma, shame and secrecy that surrounds STIs/STDs;
- Decrease health inequities especially in communities most affected by chlamydia and gonorrhea; and,
- Remove systemic barriers that contribute to high rates of STIs/STDs.

Goals of the Minnesota Chlamydia Strategy

The following goals related to five strategic arenas were developed by members of the Minnesota Chlamydia Partnership Steering Committee and volunteers representing the Minneapolis- Saint Paul area, the seven counties surrounding the Twin Cities, and various locations in Greater Minnesota.

A. Funding and Policy Issues

Goal # 1 : Sustainable and sufficient funding for prevention education, screening and treatment for patients and their partners will be available.

Goal # 2: Sustainable and sufficient funding to provide training and continuing education for health care providers will be available.

B. Raising Community Awareness

Goal # 3: Increase the awareness in the general public of the epidemic of chlamydia and its consequences.

Goal # 4: Inform 18-24 year old young people that are not in school about the chlamydia epidemic and resources available, including screening.

Goal # 5: Educate non-health care staff that work in youth-serving organizations about the Chlamydia epidemic and resources available.

C. Education in Communities

Goal # 6: Increase the number of teachers receiving basic training in, or access to, recommended guidelines for sexual health education and the prevention of chlamydia and other STDS.

Goal # 7: Reduce chlamydia disease rates in Minnesota students by educating middle and high school students about chlamydia and other STIs/STDs, as well as other topics related to sexual health.

Goal # 8: Train parents and caregivers to be the primary sexuality educators for youth by providing sexual health education guidelines and resources, including information on chlamydia, the potential consequences and information on screening and treatment.

Goal # 9: Increase the number of community members who are informed of the education that is provided to teachers, students and parents.

Goal # 10: University/College campuses participate in chlamydia and gonorrhea awareness activities during the school year, including screening.

D. Clinical Issues: Screening, Treating and Reporting

Goal # 11: Every 15-25 year old female in Minnesota should have a chlamydia test annually.

Goal # 12: Health care providers will treat every person that tests positive for chlamydia within 14 days.

Goal # 13: Health care providers treat all partners of patients who have positive chlamydia test results.

Goal # 14: Increase clinician use of and comfort with Expedited Partner Therapy (EPT) to increase partner treatment and reduce numbers of infections.

Goal # 15: MDH Partner Services staff to provide field-delivered medications to individuals positive for chlamydia who did not return for treatment.

E. Affordable and Accessible STI/STD Services

Goal # 16: The state of Minnesota will prioritize its public health care responsibility to assure affordable chlamydia screening and treatment is available for all at-risk youth.

Goal # 17: Assure that low- or no-cost screening and testing is available for at-risk youth in all communities.

Goal # 18: Assure that low- or no-cost treatment for chlamydial infections is available for at-risk youth in all communities.

Goal # 19: Increase access to chlamydia screening outside of traditional clinical settings.

Goal # 20: Promote availability of school-based clinics in school districts and colleges across the state to increase easier access to screening and treatment for all at-risk populations.

Next Steps

There is an urgent need to act in order to curb this epidemic. This Strategy begins to address many of these issues, however, not all strategic arenas could be explored in depth in 2010. Also, the work that needs to be done cannot be adequately addressed by a relatively small group of people – more participation and input is essential. The intention for this document is that it will become a “living document” into which many groups will provide ideas, suggestions, and recommendations for action. As the tactics suggested here are investigated and implemented, all of us will learn more about what works, what does not work, and what else is needed. This is just the beginning.

Minnesota is consistently ranked one of the healthiest states in the nation in several areas. However, our record in providing for the sexual health needs of our young people, especially youth of color, does not meet that standard. The Minnesota Chlamydia Partnership is committed to providing assistance to local communities and organizations in order to focus our efforts on shared, achievable priorities that will enhance the sexual health of all Minnesotans and reduce the rates of chlamydia and other STIs/STDs.



The Minnesota Chlamydia Strategy: Action Plan to Reduce and Prevent Chlamydia in Minnesota Minnesota Chlamydia Partnership, April 2011

Introduction

The *Minnesota Chlamydia Strategy* is the first comprehensive, statewide action plan to address the epidemic of chlamydia to be developed in Minnesota. More than 300 individuals and several organizations have worked together since August 2010 to create a common framework for action that can be taken to reduce the high rates of chlamydia in Minnesota.

Chlamydia is the most common sexually transmitted infection/disease (STI/STD), with over 1.2 million cases reported to the Centers for Disease Control and Prevention (CDC) from 50 states and the District of Columbia in 2009. The majority of people who are infected are under the age of 30 and African American youth are disproportionately affected. Untreated infections can cause damage to a woman's reproductive organs leading to serious, irreversible conditions, including infertility, tubal pregnancy and chronic pelvic pain. In men, it can cause a discharge from the penis or painful urination; more serious complications are possible but rare. A large number of cases go undiagnosed because most people with chlamydia are not aware of their infections and do not seek testing.

Screening for chlamydia is non-invasive and chlamydia is easily treated with antibiotics once detected. Many cases of chlamydia could be prevented with better education about chlamydia, its consequences and how to prevent it, with greater use of routine screening of sexually active young women ages 15-25 years old, and with better treatment of the sexual partners of those people who are infected.

The number of chlamydia cases in Minnesota has nearly tripled over the last 14 years, with a total of 15,294 cases reported in 2010 compared to 5,417 cases in 1996. One-third of the cases in 2010 were reported in the urban areas of Minneapolis and Saint Paul, one-third were reported in the seven-county suburban metro area surrounding the Twin Cities, and one-third were reported in Greater Minnesota.

The Minnesota Chlamydia Partnership

Purpose

The Minnesota Chlamydia Partnership (MCP), the first statewide stakeholder group to focus on chlamydia, was organized by the STD and HIV Section of the Minnesota Department of Health (MDH) and seven external partners. The purposes of the MCP are to raise awareness across the state about the epidemic of chlamydia in Minnesota among young people ages 15-25 years of age and to develop a plan of action for addressing the epidemic. The *Minnesota Chlamydia Strategy* is the culmination of those efforts.

The organizations that have partnered with MDH since March 2010 are: Hennepin County Public Health and Human Services, City of Minneapolis Department of Health and Family Support, Teen Age Medical Services, Dakota County Public Health, the Powell Women's Health Center at the University of Minnesota, Planned Parenthood of Minnesota, North and South Dakota, Medica, and the Pregnancy Resource Center at the University of Minnesota.

A Grant and the Summit on Chlamydia

In February 2010, MDH was awarded a one-time grant of \$10,000 from the National Chlamydia Coalition to address chlamydia in Minnesota. The Minnesota project was one of 10 projects funded and was selected from 65 applications from across the nation. The MDH proposal was to organize a statewide coalition that would bring individuals and organizations from the community together to discuss the chlamydia epidemic and how to address it. The initial task of the MCP was to convene a day-long Summit on Chlamydia where information on the Minnesota epidemic could be presented and possible solutions discussed.

On August 3, 2010 the first Summit on Chlamydia in Minnesota was held. More than 275 people attended the Summit to learn about the epidemic and how it impacts individuals and communities, and to discuss ideas for reducing the rates. 146 people attended in Saint Paul, Minnesota and another 131 people participated via video conference at nine locations across the state. A breakdown of the main registrant agency affiliations were as follows: Non-profit organizations (24 percent); local public health (22 percent), public health clinics (19 percent), private health clinics/providers (8 percent), educational institutions (8 percent), and health plans (3 percent). Of particular interest, 16 percent of the total audience consisted of youth.

Summit participants were asked to identify key issues and needs related to the chlamydia epidemic that they felt should be addressed. Feedback centered primarily on the following four areas:

- Information on healthy sexuality needs to be made available to everyone. Messages should offer positive images of sexuality and be applicable to people of all ages. Messages need to be consistent across all forms of media. Comprehensive sexuality education should be mandatory for all students in schools in Minnesota.
- Testing for chlamydia and gonorrhea should be a part of every routine doctor's office visit.
- Funding is needed for testing, treatment, Expedited Partner Therapy (EPT) and partner notification.
- The general public needs more information on the epidemic and how it impacts the state of Minnesota.

Guiding Principles of the Minnesota Chlamydia Partnership

The Guiding Principles were created by the MCP Steering Committee as a way of helping to focus on what is most important throughout the process of creating the Strategy and moving to action.

1. Minnesota community members will develop and own the plan; all tactics will have a "home."
2. Affected communities are involved in creating and implementing the Strategy.
3. Focus on sustainable changes.
4. Everyone's voice counts equally.
5. Leverage available resources within the Minnesota Chlamydia Partnership.
6. Utilize both community-based participatory research and evidence-based research when creating and/or planning possible actions.
7. Programming and actions must be gender inclusive.
8. Activities to eradicate and prevent chlamydia and gonorrhea must be part of a broader vision of sexual health.

The Strategy

How the Strategy Was Developed

Immediately following the Summit, five workgroups were formed around the following priority issues:

- 1) Educating teens, parents and teachers;
- 2) Educating health care providers;
- 3) Building awareness in the general public with an emphasis on groups that work with youth;
- 4) Improving access to chlamydia screening and treatment; and
- 5) Making screening and treatment more affordable for youth and young adults.

Members of the MCP Steering Committee facilitated the workgroups composed of volunteers from across the state who care about young people and the chlamydia epidemic and who want to be involved in creating solutions. Each group drafted goals and objectives, discussed implementation and evaluation issues, and recommended tactics for implementing new ideas or building on existing services.

Suggestions from participants at the Summit and recommendations from the workgroups have been combined to form this document. The process was highly interactive and there have been, and will continue to be, multiple opportunities for additional feedback. This document is a work-in-progress and will need to be adjusted and expanded over time as stakeholders discover what is working and what needs to be changed. Ongoing feedback and recommendations that fit within the parameters of the goals of the MCP are welcome from all segments of society.

How the Strategy Document is Organized

The heart of the Strategy is in **Section 1** where the goals, objectives and tactics developed by the MCP workgroups are organized under five strategic arenas:

- Funding and Policy Issues
- Raising Community Awareness
- Education in Communities
- Clinical Issues: Screening and Treatment
- Accessible and Affordable STI/STD Services

The remaining sections provide supporting information that builds the case for why the Strategy is so critical to addressing the chlamydia epidemic in Minnesota. **Section 2** explains what chlamydia is and includes information on signs and symptoms and the fact that most people have no symptoms. **Section 3** describes the extent of the epidemic in Minnesota. The data are from 2010 and were compiled by the Epidemiology and Surveillance Unit of the STD and HIV Section at MDH. Additional data are included from the Minnesota Student Survey.

Section 4 covers the impact that chlamydia has on the people affected by it, as well as an estimate of the financial burden the chlamydia epidemic places on the State of Minnesota. **Section 5** explains screening, treatment and reporting of chlamydia in Minnesota and includes the CDC recommendations for chlamydia screening and treatment. **Section 6** describes activities that are currently being done nationally, regionally and in Minnesota to address chlamydia. **Section 7** describes six overarching issues that impact all of the strategic arenas and which should be included in all discussions and action plans as appropriate.

Section 8 describes the structure and coordination of the MCP, how to continue building a statewide partnership and identifying champions, next steps, and future vision. **Section 9** offers stories about successful activities to address the epidemic of chlamydia that have been started already by organizations involved in MCP.

The **Acknowledgements** section lists all of the people who made the development of this Strategy possible. The **Glossary of Terms** includes a review of the terminology used in this document. The **References** section provides a list of articles and books where documentation the scientific research cited in this document can be found.

How to Read and Interpret this Strategy

Audiences that may be interested in the *Strategy for Reducing and Preventing Chlamydia in Minnesota* include individuals, youth-serving organizations, local and state governmental agencies, institutions, members of faith communities, correctional facilities, private and public health care providers, teachers and school officials, legislators, professional associations, social and civic clubs/organizations, businesses, non-profit agencies, health insurers and health plans, parents/guardians, teens and young adults, colleges and universities, and other members of the communities most affected by the chlamydia epidemic. There are many avenues that can be followed on the way to effective solutions to the chlamydia epidemic.

The Strategy was created as a tool for starting discussions and offering ideas for taking action. As stated in the Executive Summary, it is intended to be a “living document” that will continue to expand with input from many additional people. Obviously the ideas reflect the makeup of the workgroups that created them; it was not feasible for the workgroups to cover all possible topics. As a result, there are areas where the initial steps toward an idea are suggested, but the next steps in a process will need to be determined by the group that takes them on. There are also strategic arenas that have not yet been addressed. Hopefully this document will inspire new actions yet to be conceived.

The workgroups who met to create the ideas and recommendations in the Strategy have, in some cases, suggested types of organizations or named specific organizations that could possibly take the lead in certain situations. These are suggestions and the organizations named will need to determine whether or not these items fit their missions and if they have the resources to step in. There are also likely to be many groups/organizations that will see ways to get involved that the Strategy does not include at this point in time.

Timeframes for some of the actionable items have been included so that readers may get a feeling for the sense of urgency that members of the MCP felt as they discussed their ideas. However, these timelines are meant to be suggestions and are not rigid. MCP recognizes that groups that decide to take on any of the suggestions described in the Strategy will need to develop timeframes that fit their own organizations.

While MDH has taken the lead in the creation of the Strategy, and there are suggestions for MDH to take action on, the Strategy is not a plan for MDH only. The MCP hopes that many groups will take ownership of ideas in the Strategy and assume responsibility for actions that fit the mission and activities of their individual institutions or organizations.



The Minnesota Chlamydia Strategy: Action Plan to Reduce and Prevent Chlamydia in Minnesota

Minnesota Chlamydia Partnership, April 2011

Section 1: Goals, Objectives and Tactics for Addressing the Chlamydia Epidemic

Five workgroups composed of members of the MCP Steering Committee, along with volunteers from across Minnesota, met between September 2010 and January 2011 to research, discuss and propose actionable ideas for the Strategy. Their recommendations are grouped into five strategic arenas. Some ideas are interwoven across various strategic arenas. Most of what is included below remains in the words created by the workgroups.

Funding and Policy Issues

Two workgroups developed goals related to funding and policy issues:

Affordable Services Workgroup Members: *Ellen Young, Michele VanVranken, Stephanie Hernandez, Laura L. Eiklenborg, Chrisy Feine, Bethany Krafthefer, Christine Austin-Roehler, Lori Marti*

Accessible Services Workgroup Members: *Jessie Saavedra, Kathy Wick, Lisa Dornick, Dana Hays, Erin Pratt, Ruby Nguyen, Cynthia Haugsdal, Janne Barnett, Paula Nelson, Gloria Tobias*

It is important to talk up front about the topic of funding for all activities related to chlamydia prevention, education, screening and treatment, and other programs that support chlamydia prevention and intervention. This workgroup was charged with thinking of all possible ways in which the chlamydia epidemic could be addressed across disciplines, regardless of whether or not there was funding to support the ideas. By doing this, the workgroup participants had space to dream of possibilities without the restriction of funding concerns.

Realistically, many of the ideas included in this Strategy cannot be implemented without funding. MDH receives limited federal funding from CDC for screening and treatment of chlamydia. These funds were never intended to be the sole mechanism for funding chlamydia prevention and control efforts; it was anticipated that states would contribute additional dollars. However, state funding in Minnesota to deliver education and public awareness about chlamydia and expand and improve screening and treatment has not been forthcoming, as has been the case for most other states in the U.S. as well. In light of this, the need expressed most frequently by workgroup members is the need to advocate for and secure additional state and national funding that is sustainable and sufficient to address an epidemic as large as the epidemic of chlamydia. In order to truly make a difference, more funding is key. If we truly value our young people and want them to be successful, healthy adults, it is essential that we do what is needed.

Given the challenging economic times, the process of raising additional funding will take time and people will need to be convinced there is a problem and that it can be solved. This involves relationship and coalition building, which can begin now through the process of addressing the goals on the following page.

Goal #1:

Sustainable and sufficient funding for prevention education, screening and treatment for patients and their partners will be available.

Objective 1. By December 31, 2012, a group to be determined, in collaboration with MDH staff, will draft a policy agenda that addresses sustainable funding for screening and treatment for patients and their sexual partners.

Tactic a. Define parameters of policy agenda.

Tactic b. Identify key stakeholders that are impacted by and/or invested in these policies.

Tactic c. Work with provider organizations and other key stakeholders to collaboratively identify and design plans to implement these policies.

Objective 2. By December 31, 2012, continue and increase Infertility Prevention Project (IPP) funding to provide chlamydia screening for all individuals without insurance coverage.

Tactic a. Monitor and support national policy on continued funding for the national Infertility Prevention Project.

Tactic b. Secure state funding for chlamydia screening, testing and treatment to expand these services in Minnesota.

Objective 3. By December 31, 2014, third party payers must pay for treatment medications for partners where indicated.

Tactic a. Identify one health plan or health insurer that is receptive to exploring the implementation of this objective.

Tactic b. Identify who sets payment regulations for government-sponsored health plans and discuss adopting this objective.

Tactic c. Support legislation for public and private insurers to cover medications to treat both patients and their partners through EPT to prevent re-infection.

Objective 4. By December 31, 2014, ensure that chlamydia screening is defined and included as a preventive measure in the Affordable Care Act.

Tactic a. Monitor and support national policy on including chlamydia as a preventive measure covered in health care reform.

Goal #2:

Sustainable and sufficient funding to provide training and continuing education for health care providers will be available.

Objective 1. By December 31, 2012, a group to be determined, in collaboration with MDH staff, will draft a policy agenda that addresses sustainable funding for provider training and continuing education.

Tactic a. Define parameters of policy agenda.

Tactic b. Identify key stakeholders that are impacted by and/or invested in these policies.

Raising Community Awareness

Workgroup Members: *Dave Johnson, Marcie Babcock, Gary Greenfield, Donna Erbes, Beth Goodney*

Most Minnesotans are unaware of the epidemic of chlamydia and the impact it and other STIs/STDs have on young people and the state of Minnesota. It is important to describe the situation to average citizens and show how it impacts the economy, especially the cost of health care. We can provide information on the high numbers of adolescents and young adults that are affected, explain the risk of serious complications, discuss the need for medical and social services, and explore the complex social and cultural issues that contribute to young people becoming infected with chlamydia at such high rates. It is important to use a variety of forums to engage community members, including youth, and initiate community initiatives that can contribute to lowering the number of young people who are getting STIs/STDs. Agencies, organizations and faith communities that work with youth and understand that the possibility of getting an STI/STD is a risk factor for teens can address this fact in the context of other youth programming.

The workgroup that addressed how to increase public awareness has developed the following recommendations. This was a small group with a large arena to cover and so they also listed several additional ideas that they did not have time to research further. We have also included several suggestions that came from the feedback offered at the Summit on Chlamydia held in August 2010. Those ideas/suggestions can be used to spark new goals and objectives.

Goal #3:

Increase the awareness in the general public of the epidemic of chlamydia and its consequences.

Objective 1: By December 31, 2012 create and implement a mass-media strategy to educate the general public about chlamydia.

Tactic a. Secure funding to create and implement the mass media campaign.

Tactic b. Identify a group such as Girls in Action that would take on the development and implementation of the strategy.

Tactic c. Develop a campaign slogan.

Tactic d. Identify what messages to use with the general public.

Tactic e. Get a celebrity champion to serve as campaign spokesperson.

Tactic f. Identify mass media outlets such as radio and TV stations, and social media sites or web billboards that would provide public service announcements (PSAs).

Tactic g. Draft letters to the editor and informational pieces for use in mainstream and community news outlets.

Additional ideas from workgroup:

- Use jingles and announcements that people will remember.
- Dedicate a month to Minnesota Chlamydia Awareness.
- Educate legislators and city officials about the epidemic of chlamydia, its consequences, and what can be done to prevent it.
- Organizations can create their own campaign flyers, posters, and pamphlets to distribute among their customers.
- Promote national STD awareness campaigns such as Get Yourself Tested (GYT).
- Provide web links to the national campaigns and to testing and treatment resources available in Minnesota.

Additional ideas from small groups at the Summit:

- Provide information/flyers at public venues.
- Media attention-newspaper, radio.
- Provide more education to our partners locally.
- Maintain a roster of existing national awareness campaigns. Use more national and state media campaigns on the epidemic to help us locally with getting the message out.
- More funding for media campaigns.
- Put information on church bulletins to get the grandparents, aunties, and uncles talking about the issue and addressing as a family.
- Campaign entitled “Minnesotans know about Chlamydia /Gonorrhea.”
- Use mass media in multiple languages.
- Statewide slogan could help frame message for everyone.
- More openness that allows people to talk about STDs more easily.
- Need increase in news stories.
- Use similar media campaigns to H1N1.

Goal #4:

Inform 18-24 year old young people that are not in school about the chlamydia epidemic and resources available, including screening.

Objective 1. By December 31, 2012, a media campaign that utilizes the Internet and social media will be developed to deliver messages to at least 1,000 18-25 year olds.

Tactic a. Identify and secure a champion(s) such as a health plan or foundation to fund the awareness media campaign.

Tactic b. Retain an advertising agency to develop the media campaign.

Tactic c. Identify the clinics that offer chlamydia testing in MN. (Work with the Minnesota Family Planning and STD Hotline, the CDC Hotline and other national resources.)

Tactic d. Identify messaging for 18-25 year olds, including pertinent messages about the epidemic and clinics that offer testing. Develop messages specific to target group sub-populations (e.g., urban, suburban, small communities and rural areas; cultural groups, etc.). Messages must be available in languages other than English.

Tactic e. Develop an Internet and social media campaign strategy for implementation.

Tactic f. Pilot test messages and materials with target audiences.

Tactic g. Maintain a list of clinics that offer chlamydia testing on a publically accessible website.

Tactic h. Develop social media site on chlamydia, including a plan for updating information as necessary.

Tactic i. Implement the social media strategy.

Objective 2. By December 31, 2012, develop a grassroots messaging campaign to target 10 businesses that employ a large number of young people ages 18-25.

Tactic a. Develop campaign messages and slogans.

Tactic b. Secure funds to develop campaign materials.

Tactic c. Develop campaign promotional materials to be used in grassroots messaging. The materials can be flyers, pamphlets and posters. Materials should be made available in languages other than English.

Tactic d. Develop a list of at least 10 businesses that employ young people and design a method to gauge interest in participating in this campaign.

Tactic e. Create a campaign implementation plan.

Tactic f. Recruit outreach workers to sell the campaign to businesses and enroll them as campaign participants and ambassadors.

Tactic g. In collaboration with participating businesses, design ways to reach young employees with campaign messages.

Tactic h. Train outreach workers in delivery of campaign directly to employees of businesses.

Additional ideas from small groups at the Summit:

- Learn how to use social marketing, including texting, and have it approved through businesses and other organizations.
- Involve youth and ask them how they want to learn.
- Constant media messages.
- Engage churches and other places of worship, youth centers, shelters.
- Educate people that someone does not need to have symptoms in order to be infected with chlamydia.
- Text messaging campaign could be really effective with teenage and college-age youth.
- More PSAs on stations that youth listen to; also in a variety of media. (Example: banner ads encouraging screening on health education sites frequented by youth.)

Goal #5:

Educate non-health care staff that work in youth-serving organizations about the chlamydia epidemic and resources available.

Objective 1. By December 31, 2012, develop and promote a toolkit for staff at five youth-serving organizations that highlights the chlamydia epidemic and provides resources for follow-up that includes screening, testing and treatment.

Tactic a. Assemble and maintain a list of youth-serving organizations that could be potential partners in the effort. Identify at least five organizations that would be interested in participating.

Tactic b. Develop toolkit messages and materials and pilot with interested organizations.

Tactic c. Create an online version of the toolkit.

Tactic d. Create a monitoring and evaluation plan for the promotion of the toolkit. The plan will include the use of a tool such as Survey Monkey to evaluate the toolkit uptake.

Tactic e. Determine who will promote and maintain the toolkit.

Tactic f. Pilot toolkit with interested organizations.

Tactic g. Deliver the toolkit to staff at organizations in the following forums: One-on-one meetings; professional conferences; websites; email listservs.

Education in Communities

Workgroup Members: *Mary Thissen-Milder, Roy Nelson, Grace Anderson, Kate Bots, Kathy Brothen, Amy Brugh, August Galloway, Pam Glenn, Jamie Grilz, Atasha Jackson, Neda Kellogg, Jeff Moberg, Linda Norland, Makeda Norris, Deb Schmitzerle, Doreen Swendsen*

Adolescents need more access to healthy, positive, medically accurate and culturally appropriate information on chlamydia and other STIs/STDs. People who receive this information can, when they become sexually active, choose behaviors that will reduce their risk of becoming infected or transmitting an infection to someone else. In some schools, standards for health education have eroded in recent years. Due to political and social controversy, it has been difficult for teachers and schools to provide consistent, positive, sexual health education at any level that enhances the well-being of young people. By focusing on overall sexual health that prepares adolescents for adulthood in age-appropriate ways, situations such as contracting STIs/STDs, having unwanted pregnancies, experiencing some forms of sexual violence can be averted. This can allow adolescents the freedom to focus on the education and life experience that they need in order to grow into sexually healthy and mature adults.

Some teachers and college instructors need training in health/sexuality education and others need permission and support from school systems to teach STI/STD information effectively. Education on chlamydia, when taught in schools and universities, must be part of a comprehensive educational program that addresses all areas of sexuality. Recent efforts to require Minnesota schools to provide comprehensive sexuality education have failed, although HIV/AIDS education is mandated. In 2007 a state statute mandated STI/STD education, however, ambiguities in the statute make it unclear how it is to be enacted and enforced and as a result, not many school districts have attempted to implement it.

The strongest feedback received from people who attended the Summit on Chlamydia in August 2010 was that healthy sexual information must be made available to everyone. They want to see consistent messages about the positive aspects of sexuality presented to audiences of all ages in all venues, including television, movies and the Internet. They want to see open discussions where people can talk about sexual matters without secrecy, shame and stigma. The young people in attendance were especially vocal about wanting to get good information from caring adults they look up to, including parents as often as possible, mentors, teachers, and leaders at their churches/synagogues. They are looking to adults to lead the way.

The workgroup that addressed education focused in five areas: education and training for teachers in middle and high schools; education and training for teachers in universities and colleges; education for parents and caregivers; training for people working in community-base programs; and, information that students in all types of schools should receive.

Goal #6:

Increase the number of teachers receiving basic training in, or access to, recommended guidelines for sexual health education and the prevention of chlamydia and other STDS.

Objective 1. By December 31, 2012 an appropriate organization or coalition to be determined will prepare a report to the State Legislature recommending age-appropriate sexual health guidelines to be available for all school districts within the state.

Tactic a. Collaborate with the Minnesota Organization on Adolescent Pregnancy, Prevention and Parenting (MOAPPP) to investigate the number of Minnesota school districts that are implementing an evidence-based and peer-reviewed sexual health curricula that includes sufficient information on chlamydia at the middle school and/or high school levels.

Tactic b. Collaborate with MOAPPP to complete a literature search identifying effective sexual health education guidelines and curricula that include reduction of chlamydia and other STIs/STDs and unintended pregnancies.

Tactic c. Establish a "Review Team" of partners from the MCP to review existing sexual health curricula and resources and adapt for use in Minnesota.

Tactic d. Summarize the findings and prepare a report for the State Legislature that includes the following: status of sex education in Minnesota's school districts; evidence of health benefits of sexual health education curricula; current behavioral risk data from the MN Student Survey; and recommend curricula components.

Tactic e. Prepare a report for a potential legislative briefing and submit the final "findings" report to the State Legislature. The group should insure sufficient emphasis on the epidemic of chlamydia.

Objective 2. By December 31, 2012, an appropriate organization or coalition, to be determined, will provide three regional trainings for up to 100 teachers on providing guidelines for age appropriate sexual health education for the classroom.

Tactic a. Identify or create an online web-based location to warehouse the recommended guidelines for sexual health education curricula and resources for legislators, teachers, school board members, administrators and school district health curricula review committee to download and review. The curricula and resources will address the following:

- How to implement evidence-based curriculum into skills-based health education;
- How to incorporate options (not mandated) to the curriculum that are gender, value and culturally sensitive; and,
- Examples or models and policies for schools to follow in sex education curricula.

Tactic b. Develop, market and deliver three regional teacher workshops for school districts on how to implement sexual health education curricula.

Tactic c. Create an on-line web-based training course based on the regional workshops that teachers can access from their personal or school district computers on how to deliver sexual health education in the classroom.

Tactic d. For a comprehensive sexuality education (CSE) program for American Indian youth, the existing effort between the University of Minnesota's Program in Public Health, MDH and the Indigenous Peoples' AIDS Task Force Statewide Advisory Council will be utilized.

Goal #6, continued:

Objective 3. By December 31, 2012, an appropriate organization or coalition to be determined will provide up to 10 trainings to reach up to 50 health education pre-service teachers in higher education institutions (post-secondary schools) on guidelines for age-appropriate sexual health education for the classroom.

Tactic a. Develop an on-line web-based location for the recommended guidelines for sexual health education curricula and resources.

Tactic b. Adapt and provide pre-service teachers with workshops on how to implement sexual health education curricula and resources.

Tactic c. Create an on-line webinar for implementation of guidelines for sexual health education curricula.

Tactic d. Identify trained professionals to serve as mentors to pair with pre-service teachers in higher education to provide assistance in implementing sexual health education curricula and resources.

Tactic e. For CSE guidelines specific for American Indian youth, the existing effort between the University of Minnesota's Program in Public Health, MDH and the Indigenous Peoples' AIDS Task Force Statewide Advisory Council will be utilized.

Goal #7:

Reduce chlamydia disease rates in Minnesota students by educating middle and high school students about chlamydia and other STIs/STDs, as well as other topics related to sexual health.

Objective 1. By December 31, 2012, up to 100 teachers, trained on providing age-appropriate sexual health education including instruction on sexually transmitted diseases with an emphasis on chlamydia, will provide instruction for up to 3,000 students.

Tactic a. An appropriate organization or coalition to be determined will develop pre- and post-knowledge and behavior assessments for students regarding sexual health to utilize while implementing the sexual health curriculum.

Tactic b. Health teachers will administer pre- and post-knowledge and attitude assessments relative to sexual health to students before and at the conclusion of the sexual health unit.

Tactic c. Health teachers will administer curriculum to students with implementation notes documented by teachers on curriculum logs.

Tactic d. In collaboration with MDE, health teachers will evaluate both student growth and teacher implementation comments to determine successes and challenges to be addressed prior to next implementation.

Objective 2. By December 31, 2012, an appropriate organization or coalition to be determined, along with MOAPPP, the University of Minnesota and MDH, through the STD and Family Planning Hotline, will provide up to 50 percent of Minnesota school districts with selected promotional materials on how to access medically accurate STI/STD and reproductive health education and resources for students outside the classroom. The coalition must insure that sufficient information on chlamydia (the epidemic proportions, consequences and information on screening and treatment) will be included.

Tactic a. Identify and recommend standardized and evidence-based STI/STD and CSE curricula for school districts to use to reach students outside the classroom.

Tactic b. Identify and/or develop lesson plans about STIs/STDs that can be incorporated within other non-health school subjects such as math, biology, sociology, etc.

Tactic c. Identify and/or develop reference materials about STIs/STDs that athletic coaches can use with their players to promote ways of avoiding chlamydia and other STIs/STDs and encouraging screening as needed.

Tactic d. Develop articles about chlamydia and other STIs/STDs for use with student school newspapers.

Tactic e. Identify and/or develop reference materials about chlamydia and other STIs/STDs that school nurses can use with students to assess sexual risk and promote ways of avoiding STIs/STDs and encouraging screening as needed.

Tactic f. Organize teams of peer educators from student organizations that can deliver education on chlamydia and other STIs/STDs and reproductive health-related topics in the classroom.

Tactic g. Develop a resource list of agencies (universities, teen councils, etc.) that sponsor peer educator programs to come to classrooms and deliver information on chlamydia and other STIs/STDs and reproductive health.

Goal #7, continued:

Objective 3. By December 31, 2012, up to 100 trained teachers will provide promotional information to up to 3,000 students regarding access to social and web-based networking platforms promoting individual responsibility for positive sexual health.

Tactic a. The Minnesota Family Planning and STD Hotline will distribute marketing materials for the Hotline to use as a resource for responding to inquiries, locating testing facilities and referrals for treatment and care.

Tactic b. An appropriate organization/coalition, in collaboration with the STI/STD Hotline will develop and promote a directory of popular youth Internet links (MTV, VH1, YouTube, etc.) that also provide online chlamydia and sex education information that addresses topics such as romance, empowerment, relationships, benefits of waiting to have sex, oral sex risks, myths and prevention messages for GLBT youth.

Tactic c. Organizations and coalitions will promote national STI/STD campaigns and corresponding links on social media outlets.

Tactic d. An appropriate organization/coalition, to be determined, will work with the Greater Metropolitan Council of Churches to provide faith-based institutions (churches, synagogues, temples, mosques) and organizations with sexuality education lesson plans that include information on chlamydia and other STIs/STDs that can be used with their youth groups and programs.

Goal #8:

Train parents and caregivers to be the primary sexuality educators for youth by providing sexual health education guidelines and resources, including information on chlamydia, the potential consequences and information on screening and treatment.

Objective 1. By December 31, 2012, an organization/coalition to be determined will identify or develop sexual health educational guidelines, strategies for parental involvement in curriculum development, and collateral resources for parents, grandparents, guardians and other caregivers for use in their homes.

Tactic a. Conduct a comprehensive literature search to identify existing educational curricula and resources that can be used by parents, grandparents, guardians, extended families, faith-based communities and other role models connected with the family to provide effective sexual health education in the home.

Tactic b. Establish “Review Teams” of local educators and parent leaders from the community and faith-based settings to review existing sexual health curricula and resources and develop a draft curricula for use in the home that are compatible/complementary to those used in schools and other community settings.

Tactic c. Host focus groups and obtain input and feedback from parents, grandparents, guardians and faith-based communities with the newly developed standardized sexual health educational curricula and revise as needed.

Tactic d. Field test and evaluate the newly developed and revised standardized sexual health educational curricula and collateral resources with parents, grandparents, guardians, extended families, faith-based communities and other role models connected with the family for use with youth in the home.

Tactic e. Compile a compendium of curricula and resources for parents, grandparents, guardians, extended families, faith-based communities and other role models connected with the family for use with youth in the home.

Objective 2: By December 31, 2012, an organization/coalition to be determined will provide three regional trainings to parents/grandparents/guardians on providing sexual health education in the home. (Note: It is suggested to do more locally-based trainings rather than regional trainings.)

Tactic a. Identify organizations and agencies serving parent/guardians (PTAs, Community Education, etc.) capable of providing workshops or teams of “parent peer educators” on how to provide sexual health education in the home.

Tactic b. Identify and recruit parent leaders or organizations and agencies serving parents and guardians willing to become “parent peer educators.”

Tactic c. Develop and market train-the-trainer workshops for organizations and agencies serving parents and guardians on how to conduct workshops or organize teams of “parent peer educators” for parents and guardians on home-based sexual health education.

Tactic d. Conduct three regional workshops for parents, grandparents, and guardians to provide sexual health education in the home.

Tactic e. Create an online web-based training course from the regional workshops that parents, grandparents, guardians and other caregivers can access from their home computers on how to deliver sexual health education in the home.

Goal #8, continued:

Objective 3: By December 31, 2012, fifty (50) percent of the parents who received training on home-based sexual health education guidelines and resources will become engaged in school programs and practices in sexual health.

Tactic a. Create, promote and maintain an online “parents are part of the solution” website that addresses: importance of, justification for, and evidence to support home-based sexual education for parents and guardians and for community based sexual education to faith-based communities; provide sample downloadable standardized educational curricula and resources for parents, grandparents and guardians and links for online training and continuing education courses.

Tactic b. At the discretion of local school district administrations, host an annual “Open House” at the beginning of each school year in all Minnesota districts to review the districts’ curricula on all subjects, including classroom sexuality education.

Tactic c. At the discretion of local school district administrations, schools will provide information to parents and guardians about when sexuality education occurs in the classroom through a letter or other informational delivery means usually used by the district. The letter will clarify what is being delivered and who is delivering it.

Tactic d. Provide directions to parents and guardians on how to access the online standardized sexuality education curricula and resources during the time when the lesson plans are being implemented in the classroom.

Goal #9:

Increase the number of community members who are informed of the education that is provided to teachers, students and parents.

Objective 1. By December 31, 2012, a coalition of agencies made up of MDH, MDE, MOAPPP and at least one health plan will develop four informational vehicles for the school districts' surrounding general community to learn about chlamydia and other STIs/STDs and CSE.

Tactic a. A community partnership of agencies including MDH, MDE, MOAPPP, health plans and local community adult education will identify and/or create an online web-based information site so that general community members can visit and learn about their local curriculum development policies specific to community involvement, and what is being taught at their local schools about chlamydia and other STIs/STDs and comprehensive sexuality education.

Tactic b. Through ECHO public television, a community partnership of agencies including MDH, MDE, MOAPPP and health plans will develop a 30 minute DVD program on STDs that includes information on chlamydia and the epidemic in MN, the role the general community has in reducing the rates of chlamydia and other STIs/STDs, the importance and benefits of CSE that can be played on community or school district cable television programs.

Tactic c. Prior to National STD Awareness Month (April of every year), MDH will assemble links for free, downloadable television, radio and print public service announcements and send them to all media outlets statewide for use during the awareness month to inform communities about the chlamydia epidemic and the importance of screening, as well as information on the other STIs/STDs.

Goal #10:

University/College campuses participate in chlamydia and gonorrhea awareness activities during the school year, including screening.

Objective 1: By December 31, 2012, students will organize to develop and implement an awareness campaign about chlamydia and other STIs/STDs to inform the university/college student population about STIs/STDs, with a focus on chlamydia prevention, screening and treatment.

Tactic a. Organize an STI/STD/Sexual Health Awareness Committee on campus to plan for National STD Awareness Month (April) each year to reach enrolled students with information on chlamydia and other STIs/STDs.

Tactic b. The STI/STD/Sexual Health Awareness Committee will work with university administrators, faculty, staff, student health service, residential dorm advisors, and campus organizations to organize an STI/STD Awareness Month awareness campaign plan to include chlamydia testing, seminars, events/games, campus paper articles/editorials, campus radio station interviews/PSAs, film festival, student center/union exhibits, and/or social media messaging.

Tactic c. The STI/STD/Sexual Health Awareness Committee will submit the STI/STD Awareness Campaign Plan to campus administration for approval and to obtain financial support for the campaign implementation.

Tactic d. The STI/STD/Sexual Health Awareness Committee will obtain existing and/or develop STI/STD related messages, posters, brochures, print and radio PSAs, fact sheets and other educational materials that will be used in conjunction with STI/STD Awareness Month campus activities.

Tactic e. The STI/STD/Sexual Health Awareness Committee will promote the schedule of STI/STD Awareness Month activities via campus-based newspapers, radio stations, cable stations, social media sites, and university/college web site.

Tactic f. The STI/STD/Sexual Health Awareness Committee will create a monitoring and evaluation plan for the campaign and will meet after the campaign to review the strategies used and make recommendations for the subsequent year.

Objective 2: By December 31, 2012, an organization/coalition to be determined, will provide trainings to reach up to 50 health education pre-service teachers in higher education institutions (post-secondary schools) on guidelines for creating sexual health education for the classroom and skills for implementing curricula.

Tactic a. Develop an on-line web-based location for the recommended guidelines for sexual health educational curricula and resources.

Tactic b. Create an on-line webinar for implementation of guidelines for sexual health educational curricula.

Tactic c. Identify trained professionals to serve as mentors and pair them with pre-service teachers in higher education to provide assistance in implementing sexual health educational curricula and resources.

Clinical Issues: Screening, Treating and Reporting

Workgroup Members: *Shereese McIntosh, Jennifer Oliphant, Candy Hadsall, Ajay Behl, Amy Gilbert, Marcie Bordelon, Jennifer Harvey, Erin Francis, Holly Dukowitz, Jeanne Rancone, Michelle Wheeler, Patricia Dumonceaux, Peter Carr, Vicki Iocco, Sheila Pelzel*

Many people may have been under the impression that chlamydia was just a medical issue that the medical community should handle. However, health care providers in settings outside of dedicated STI/STD and family planning clinics are often not very knowledgeable about the epidemic proportions of chlamydia and who is most likely to be infected. As a result, they need to know how to do a much better job of screening young women and treating those who are positive.

In addition, sexually active individuals can learn to be more assertive in asking their providers questions about sexuality and STIs/STDs during their office visits and requesting screening. They can also be more helpful in assuring that their sexual partners get treated if providers are comfortable talking about sexual health.

The second topic most frequently discussed at the Summit on Chlamydia was the need for youth to be able to easily access screening and treatment that is routinely offered, is free or very inexpensive and is provided in a manner that assures their confidentiality is maintained.

The workgroups that addressed clinical issues and their impact on youth and communities worked in several strategic arenas. One group devoted its attention to ways to improve services including educating providers on how to be more comfortable talking about sex and conducting sexual histories, increasing screening and treatment in clinics, getting more partners treated including advancing EPT, and removing barriers to patient confidentiality.

Goal #11:

Every 15-25 year old female in Minnesota should have a chlamydia test annually.

Objective 1. By December 31, 2011, appropriate members of the MCP and staff from MDH will communicate with health plans and with professional organizations that represent physicians, nurse practitioners, and physician assistants regarding ways to increase chlamydia screening.

Tactic a. Develop appropriate education for providers (especially in obstetrics/gynecology, pediatrics, family practice and adolescent medicine) on best practices in screening.

Tactic b. Identify people in each clinical setting that will champion annual screening for all females ages 15-25.

Objective 2. By June 30, 2012, professional organizations and health plans will provide clinical evidence to health care providers on the importance of screening and how to overcome barriers.

Tactic a. Conduct a literature search, obtain copies of and read current research on barriers to conducting screening for chlamydia expressed by providers.

Tactic b. Disseminate findings of literature search.

Objective 3. By June 30, 2011, identify rationale that support the short-term and long-term cost effectiveness of providing annual screening for 15-25 year old females.

Tactic a. By June 30, 2011 Ajay Behl of Health Partners will research and draft the short-term and long-term rationale that support annual screening of females ages 15-25 for chlamydia, and provide this information to the STD Clinical Consultant at the MDH and to members of the MCP.

Tactic b. Identify best clinical practices for chlamydia screening based on the above rationale.

Tactic c. Disseminate best practices related to screening to health care providers across the state.

Additional ideas generated by the workgroup:

- Develop a broader strategy to encourage young people to be screened at least once a year.
- Design a strategy to market chlamydia screening to young adults.
- Work with schools and other organizations to explore alternative testing options. (Examples: universal testing in the schools, testing on the street, new test using Smart Phone application, tests available in pharmacies, tests ordered online).
- Decide who gets funding and determine a method of distribution for funding; include funding for infrastructure.

Goal #12:

Health care providers will treat every person that tests positive for chlamydia within 14 days.

Objective 1. By June 30, 2012, an appropriate organization or coalition will disseminate best practice guidelines that facilitate prompt treatment at the location of diagnosis.

Tactic a. Measurement systems that document completion of treatment are in place at the clinic level.

Tactic b. MDH will assure that best practices related to treatment of chlamydia are in place in clinics in Minnesota.

Tactic c. Create and disseminate benchmarks related to the implementation of best practices to health care providers in Minnesota.

Objective 2. By June 30, 2012, an appropriate organization or coalition will disseminate data (such as HEDIS data provided on CDC website) on the consequences of delayed or untreated chlamydia.

Tactic a. Ajay Behl will assemble the evidence on the consequences of delayed and untreated chlamydia.

Tactic b. Present new information on the outcomes related to the consequences of delayed or untreated chlamydia at conferences such as the Minnesota Reproductive Health Conference, the annual conference of school nurses, and on the MDH website.

Goal #13:

Health care providers treat all partners of patients who have positive chlamydia test results.

Objective 1. By December 31, 2012, conduct a literature search and compile the information that evaluates the safety, liability and cost effectiveness of treating partners.

Tactic a. Recruit an MDH student to conduct literature search.

Tactic b. The STD and HIV Section at MDH will research and/or develop tools for providers to contact and treat partners.

Tactic c. Provide links to online training resources that provide CMEs to educate providers on how to contact and treat partners.

Tactic d. Explore effective patient and partner notification strategies and make this information available to providers.

Tactic e. Provider education programs will have information on what EPT is, why providers should utilize EPT whenever appropriate, the impact it can have on rates of disease, and the cost effectiveness of implementing EPT.

Goal #14:

Increase clinician use of and comfort with EPT to increase partner treatment and reduce numbers of infections.

Objective 1. By December 31, 2012, an appropriate organization or coalition to be determined will address the lack of awareness of EPT as a treatment modality and barriers to clinician use of EPT through provider and public education.

Tactic a. Confer with MDH staff and the California Department of Health's STD Control regarding the current use of EPT, pilot studies that are underway, barriers to use, and effective strategies for implementing EPT. MDH staff to publish pilot study results and make broadly available to provider groups.

Objective 2. By December 31, 2012, an appropriate organization/coalition to be determined will work with health plans to promote EPT practice standards among providers and to pay for universal coverage for partner therapy.

Tactic a. Make the provision of EPT when treating patients for chlamydia a HEDIS measure for all clinics and health systems.

Tactic b. Form a legislative policy group to develop legislation that requires all private health plans to provide reimbursement to pharmacies and clinics for medications provided to patients who are positive for chlamydia to give to their partners.

Tactic c. Meet with the Department of Human Services and inform them of the need for all PMAP plans to provide reimbursement to pharmacies for EPT effective the next time contracts are renewed.

Goal #15:

MDH Partner Services staff to provide field-delivered medications to individuals positive for chlamydia who did not return for treatment.

Objective 1. By December 31, 2011, in conjunction with their current role of notifying partners of people who are positive for gonorrhea, syphilis and HIV, disease investigators at MDH will provide field-delivered medications to individuals positive for chlamydia who did not return for treatment

Tactic a. Partner Services staff at MDH to develop protocols for field-delivered therapy.

Tactic b. Train Partner Services staff on how to implement field-delivered therapy.

Tactic c. Secure medications to be used in field-delivered therapy.

Affordable and Accessible STI/STD Services

Affordable Services Workgroup Members: *Ellen Young, Michele VanVranken, Stephanie Hernandez, Laura L. Eiklenborg, Chrisy Feine, Bethany Krafthefer, Christine Austin-Roehler, Lori Marti*

Accessible Services Workgroup Members: *Jessie Saavedra, Kathy Wick, Lisa Dornick, Dana Hays, Erin Pratt, Ruby Nguyen, Cynthia Haugsdal, Janne Barnett, Paula Nelson, Gloria Tobias*

In order for STD/STD services to be utilized effectively, screening and treatment must be both affordable and accessible. The absence of either one of those is a barrier to anyone taking responsibility for their health. When either of these barriers exist for youth, the likelihood is greater that they will not access services. Two workgroups were asked to discuss these issues separately so that a full range of information could be explored.

One workgroup investigated ways that screening and treatment could be made more affordable or free to uninsured or underinsured young people so that they can seek those services when needed without worrying about payment. People who are fearful they cannot afford to pay for screening and treatment will avoid getting the help they need, especially if they are unaware they are infected or do not believe they might be at risk. Also, as the costs of health care services continue to rise, the cost of providing chlamydia screening and treatment increases. Clinics that serve uninsured populations especially need the cost for laboratory services to stay as low as possible so that they are able to utilize their funds to screen and treat more people.

The other workgroup looked at ways to make screening and treatment more easily accessible to youth. They discussed the problem that youth in rural areas may face where services may be great distances apart and they do not have the transportation needed to get to a clinic. They also discussed the fact that youth may fear that the services they receive in small communities where they and their families are known to clinic personnel will not be private or confidential. This workgroup came up with goals, objectives and tactics that provide potential alternatives to traditional screening and treatment settings.

Goal #16:

The state of Minnesota will prioritize its public health care responsibility to assure affordable chlamydia screening and treatment is available for all at-risk youth.

Objective 1: By December 31, 2011, an organization/coalition to be determined will document and demonstrate the cost-effectiveness of chlamydia screening versus the costs associated with complications resulting from untreated chlamydial infections.

Tactic a. Evaluate current data to determine the return on investment in screening and treatment for chlamydia vs. the complications resulting from untreated chlamydial infections.

Objective 2: By June 31, 2012, an organization/coalition to be determined will develop a common understanding among stakeholders of the incidence of chlamydia and the savings incurred through early screening and treatment in order to support increased financial support for screening in Minnesota by broadly disseminating the results to stakeholders.

Tactic a. Publish a fact sheet and/or policy brief that demonstrates the incidence of chlamydia in Minnesota and the costs averted by early screening and treatment.

Tactic b. Disseminate the fact sheet and/or policy brief statewide to stakeholders (funders, legislators, public health departments, insurance companies, health plans, medical providers, media, etc.) to garner support for additional funding for affordable screening, testing and treatment of chlamydia.

Goal #17:

Assure that low- or no-cost screening and testing is available for at-risk youth in all communities.

Objective 1: By December 31, 2011, staff from the STD and HIV Section at the MDH will meet with the MDH Public Health Laboratory director and State Epidemiologist to discuss MDH priorities and funding, and the pressing need for low cost chlamydia tests in order to lower the cost that clinics pay for testing so that realized cost savings may be transferred to patients. If this is not possible, MDH will recommend alternative labs that agree to provide tests at lower prices.

Tactic a. Research and disseminate to stakeholders the cost savings for using the state lab as the primary lab or labs recommended by MDH for chlamydia testing.

Tactic b. MDH recommends that community clinics and public health entities use the state lab or alternative labs approved by the MIPP to perform their tests.

Objective 2: By December 31, 2012, an organization/coalition to be determined will identify costs and savings associated with alternative or non-traditional screening sites (e.g., school-based clinics, community events, drug stores, big box stores, etc.)

Tactic a. Use research and data available to promote financial support from stakeholders to secure consistent funding streams for chlamydia screening in traditional and non-traditional settings.

Tactic b. Utilize MCP, stakeholders and media to increase public awareness of affordable testing options.

Goal #18:

Assure that low- or no-cost treatment for chlamydial infections is available for at-risk youth in all communities.

Objective 1: By December 31, 2012, an organization/coalition to be determined will advocate for azithromycin to be included in the formularies at pharmacies providing \$4/dose pricing. (Examples: Target, WalMart)

Tactic a. MDH to meet with Target, Walmart, Walgreens, CVS, etc. to provide education about the incidence of chlamydia and the initiative to increase access to treatment.

Objective 2: By December 31, 2013, MDH will support community clinics to enable them to have azithromycin in stock to immediately provide treatment to patients in need of treatment and EPT for their partners.

Tactic a. Persuade pharmaceutical companies to (do the right thing) and consistently provide community clinics with samples of azithromycin so that medications can be distributed to patients and their partners with no cost to the individuals.

Goal #18, continued:

Objective 3: By December 31, 2012, staff at the MDH will educate providers about EPT so that providers can incorporate EPT into their practices.

Tactic a. Develop and distribute marketing materials to educate patients and providers about chlamydia re-infection and EPT. This could include discussions with pharmaceutical companies and insurers/payers to ask them to develop marketing/educational materials.

Objective 4: By December 31, 2013, MDH staff will educate patients about re-infection and the importance of taking their medications as prescribed, ensuring that their partners are treated (using EPT when necessary), and returned to their clinic in 3-4 months for rescreening. This is especially important when patients do not choose to utilize EPT for their partners.

Objective 5: By December 31, 2012, an organization/coalition to be determined will advocate for insurers and health plans to pay for medications to treat partners using EPT whether or not partners are subscribers.

Tactic a. MDH to provide leadership to meet with insurers and health plans to discuss current data that supports EPT and explore the feasibility of covering the cost of treating partners whose treatment is not covered by insurance or a health plan.

Goal #19:

Increase access to chlamydia screening outside of traditional clinical settings.

Objective 1. By June 30, 2012, an organization/coalition to be determined will explore the feasibility and cost of implementing home-based chlamydia screening in Minnesota.

Tactic a. Evaluate well-researched home-based screening options available for implementation via pharmacies and the Internet and offer state support in national forums for FDA approval of home-based tests to move out of research and into public health practice.

Tactic b. Conduct research on cost effectiveness and cost comparisons of different approaches to chlamydia screening (e.g., home-based tests, point-of-care tests and treatment vs. clinical site screening; use of non-medical personnel in point-of-care urine tests and outreach) to guide the judicious use of health care resources. Confer with Johns Hopkins Medical Center (Charlotte Gaydos, Ph.D.) for information on their research and program “iwantthetest.org”, and costs associated with setting it up statewide.

Tactic c. MDH conducts a pilot project with MIPP funding of point-of-care tests and treatment to evaluate costs and the effectiveness in reaching and successfully treating at risk males and females ages 15-25 years of age with the goal of moving this screening from research to standard public health practice.

Tactic d. Meet with the MDH Public Health Laboratory director and State Epidemiologist to discuss MDH priorities and funding, and the pressing need for low-cost chlamydia tests in order to implement the above alternative screening measures as well as offer lower cost testing that can create broader access via clinics and other sites.

Objective 2. By June 30, 2012, an organization/coalition to be determined, along with MDH, will identify existing mobile STD and HIV testing sites and explore the possibility of collaboration and the feasibility of implementing mobile screening and testing in high risk communities in the seven-county metro area and in Greater Minnesota.

Tactic a. Contact Minnesota AIDS Project (MAP) director to discuss their experience with mobile testing, and the feasibility of collaborating with them to collect urine specimens for chlamydia screening simultaneously with HIV testing.

Tactic b. Explore the feasibility of providing treatment for people positive for chlamydia via mobile van.

Tactic c. If appropriate, seek expansion of MAP funding to implement these additional features of their testing and outreach in high risk communities.

Tactic d. Contact needle exchange programs and discuss the feasibility of expanding the use of their vans for urine chlamydia screening and treatment.

Objective 3. By December 31, 2012, MDH will support the use of and funding for point-of-care tests (urine/self-collected vaginal swabs) for chlamydia screening in community-based settings and non-clinical settings that reach 15-25 year old females and males.

Tactic a. In the next funding cycle for MIPP, require all MIPP-funded sites to offer outreach with point-of-care testing and treatment in non-traditional venues, and offer free treatment for individuals with positive home-based tests.

Tactic b. Require Planned Parenthood MIPP sites in Greater Minnesota to offer home-based or point-of-care screening and treatment for individuals with positive home-based test results at no cost to individuals.

Goal #20:

Promote availability of school-based clinics in school districts and colleges across the state to increase easier access to screening and treatment for all at-risk populations.

Objective 1: By December 31, 2012, an organization/coalition to be determined will contact local hospitals, medical groups, clinics and health systems about sponsoring the development of school-based clinics or school-based chlamydia screening and treatment in local high schools, technical schools and colleges.

Tactic a. Contact Mayo Health Systems (and other health systems in Greater MN) regarding sponsorship possibilities; educate them about the epidemic and cost effectiveness data of early screening and treatment.

Tactic b. Utilize local public health departments to initiate outreach to schools, clinics, health systems and hospitals in local communities to begin the collaborative process.

Tactic c. Meet with MDH Laboratory to discuss the feasibility of providing low cost lab testing for chlamydia, or assistance to find a lab willing to provide low cost lab services for use in school based settings.

Objective 2: By June 30, 2012, an organization/coalition to be determined will garner the support and collaboration of school nurses (especially in Greater Minnesota) and the School Nurse Organization of Minnesota to recommend that school health classes include information on STI/STD screening and treatment options for students in high schools. Consider similar outreach to health care providers at local technical schools and colleges.

Tactic a. Encourage local public health departments to educate school districts, health teachers and school nurses regarding the chlamydia epidemic and need for STI/STD screening and treatment in school-based settings.

Tactic b. Work with and garner the support of State School Health Coordinator (Cheryl Smoot at MDH) regarding the feasibility, educational and funding needs of school health personnel and systems to implement school-based screening and treatment.

Tactic c. Apply to provide a presentation on chlamydia at the annual SNOM conference to educate school nurses and health providers about the epidemic and strategies for screening and treatment.

Additional Idea:

Make available the chlamydia toolkit for providers that was developed, implemented and evaluated by Dakota County Public Health through a grant from Medica. See that it is distributed to all family practice and pediatric clinics in Dakota County and implemented effectively.

Next Steps

From Planning to Action

During 2011, Steering Committee members will go out to communities and organizations in Greater Minnesota and the Twin Cities metro area and meet with people who want to understand the chlamydia epidemic, discuss ideas in the Strategy, and organize ways to tackle the issues listed in the Strategic Arenas. We hope to identify “champions” who will begin exploring ways to implement recommendations from the Strategy within their current structures. Where there is no easily identifiable entity or existing structure, we are interested in identifying groups and/or individuals that are willing to begin organizing local and regional coalitions to lead local efforts. Until funding for these efforts is obtained, the MDH, with the assistance of members of the MCP when possible, will provide technical assistance or capacity building on a limited basis. However, the MCP will attempt to link local groups to state and national organizing efforts and training opportunities that can enhance the capacity of local groups to address these issues.

Commitment to Results

The MCP is committed to taking whatever steps are possible to address the sexual health needs of young Minnesotans and ultimately reduce the rates of chlamydia. Unfortunately, there are no funds dedicated to these efforts as of April 2011. One of the first strategic arenas that needs to be addressed is how to increase funding for prevention, screening, treatment and education programs for youth and the general public.

Until adequate funding is achieved, the MCP and its partners will need to identify those tactics or ideas that can be accomplished with little or no additional funding. There are many things that can be done, especially within the framework of existing programs, without additional funding, provided we have the will to do them.

There will need to be policy changes enacted at the individual organizational level and at the legislative level. The MCP acknowledges that there are significant state and national budget concerns in 2011. The MCP also realizes that efforts to discuss the need for funding of prevention and screening programs related to sexually transmitted infections and diseases can be difficult and complicated by many competing interests. Despite this, we must acknowledge the exceptionally high numbers of people who are infected, especially those who are infected and do not know it, and the need to provide adequate public health and social services in line with national priorities. Simple, quick, easy responses to a problem as complex as the chlamydia epidemic do a disservice to our young people and are not be acceptable. Solutions will take in-depth, well-informed discussions with people representing all sides of the issue, including persistence, negotiation and long-term planning.



The Minnesota Chlamydia Strategy: Action Plan to Reduce and Prevent Chlamydia in Minnesota Minnesota Chlamydia Partnership, April 2011

Section 2: What is Chlamydia?

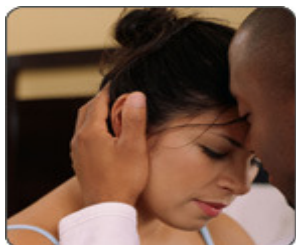
Chlamydia is a common STI/STD caused by the bacterium, *Chlamydia trachomatis*. Chlamydia and gonorrhea, another sexually transmitted infection, are the primary causes of infertility and other long-term reproductive health problems in women. When diagnosed, chlamydia can be easily treated and cured. It can also be easily prevented with the consistent use of condoms.

How Do People get Chlamydia?

Chlamydia can be transmitted during unprotected vaginal, anal, or oral sex. Any sexually active person can be infected with chlamydia. The greater the number of sex partners, the greater the risk of infection. Chlamydia can also be passed from an infected mother to her baby during vaginal childbirth.

Who Is At Risk for Contracting Chlamydia?

Anyone who is sexually active is potentially at risk of getting the infection. Because the cervix (opening to the uterus) of teenage girls and young women is not fully matured and is more susceptible to infection, they are at particularly high risk for infection if sexually active. Men who have sex with men are also at risk for chlamydial infection.



What Are the Symptoms?

Chlamydia is known as a "silent" disease because 75 to 80 percent of women and 50 percent of men who are infected have no symptoms. If symptoms do occur, they usually appear within one to three weeks after exposure. In women, the bacteria initially infect the cervix and the urethra (urine canal). Women who have symptoms might have an abnormal vaginal discharge or a burning sensation when urinating. If the infection spreads from the cervix to the fallopian tubes (tubes that carry fertilized eggs from the ovaries to the uterus), some women will have lower abdominal pain, low back pain, nausea, fever, pain during intercourse, or bleeding between menstrual periods; others will have no signs or symptoms.

Untreated chlamydia in men typically causes urethral infection. Men with signs and symptoms might have a discharge from their penis or burning and itching around the penis and a burning sensation when urinating. Untreated chlamydia may also result in complications such as swollen and tender testicles, however, this is uncommon. Most infections among men produce symptoms within a few days but testing may not be soon enough to prevent transmission to others.

Men or women who have receptive anal intercourse may acquire chlamydial infection in the rectum, which can cause rectal pain, discharge, or bleeding. Chlamydia can also be found in the throats of women and men having oral sex with an infected partner. Having chlamydia in the throat and mouth may not produce any complications, although it is unclear how much oral infections contribute to the transmission of chlamydia. More research is needed.

What Are the Complications?

Since most people infected with chlamydia are not aware of their infections, they do not seek health care until serious damage has already occurred. In women, untreated infection can spread to the uterus or fallopian tubes and cause pelvic inflammatory disease (PID). Up to 40 percent of women with untreated chlamydia will develop PID.

Inflammation of the upper genital tract can cause permanent damage to the tubes, uterus and surrounding tissue. The damage causes scarring in the fallopian tubes that will prevent eggs from moving down into the uterus to be fertilized, resulting in infertility in approximately 20 percent of women. The scarring can also allow the eggs to get part way down the tubes where, if they become fertilized, it will result in a life-threatening tubal pregnancy, something that affects approximately 9 percent of women with PID. Damage to the reproductive organs can also result in pelvic pain, a debilitating and chronic condition that happens to approximately 17 percent of women with PID and that affects the quality of a woman's life long after her childbearing years are over.

Complications among men are rare. Infection sometimes spreads to the epididymis (the tube that carries sperm from the testes), causing pain, fever and, rarely, sterility.

Genital chlamydial infection can also cause arthritis that can be accompanied by skin lesions and inflammation of the eye and urethra (Reiter's syndrome); however, this is very rare.

How Does Chlamydia Affect a Pregnant Woman and Her Baby?

Chlamydia can be passed from an infected mother to her baby during vaginal childbirth. There is some evidence that untreated chlamydial infections can lead to premature delivery. Babies who are born to infected mothers can get chlamydial infections in their eyes and respiratory tracts. Chlamydia is a leading cause of early infant pneumonia and conjunctivitis (pink eye) in newborns.



Why Are Young Women at Higher Risk?

Age and gender have an influence on the level of risk for becoming infected with STIs/STDs. Female adolescents and young women are more susceptible to chlamydia than their male counterparts because of the biological characteristics of their anatomy. The cervix (opening to the uterus) of teenage girls and young women is not fully matured, making it easier to become infected. Also, STIs/STDs are transmitted more easily from men to women than from women to men. Women are more likely to experience serious complications from infections than are men. In addition, young women and female adolescents may find it more difficult than men to implement protective barriers, partly because of the power imbalance between men and women. For example, condoms are the most effective protection against chlamydia, but the decision whether or not to use a condom is ultimately up to the male partner, in most cases, and negotiating condom use may be difficult for women. The advent of the female condom has provided a more empowered choice for women and lessened the responsibility for males to some extent. However, female condoms are still not widely used and are more expensive than male condoms, resulting in less frequent usage.

How Common is Chlamydia?

Chlamydia is the most frequently reported bacterial sexually transmitted disease in the United States. In 2009, a total of 1,244,180 chlamydial infections were reported to CDC from 50 states and the District of Columbia. Since most people with chlamydia are not aware of their infections and do not seek testing, it is assumed that the number of cases is actually much higher. An estimated 2.8 million infections occur annually in the U.S. Women are frequently re-infected if their sex partners are not treated.

The actual number of people who are infected with chlamydia in Minnesota is unknown since so many people who may be infected do not seek screening. We do know that adolescents and young adults ages 15-24 accounted for 69 percent of the cases that were reported to the MDH in 2010. Seventy-five (75) percent of people infected in Minnesota are females and the majority of them are under age 25. This means that screening of young women who are at risk and are probably not symptomatic is extremely important. For more details, please refer to **Section 3** of this document.

How Is Chlamydia Detected and Treated?

To help prevent the serious consequences of chlamydia and thereby reduce health care costs, early detection through clinical screening for the disease is paramount. Newer laboratory tests have been

Other Contributing Factors:

- Vaginal douching can increase the risk of infection, especially for PID. The risk for PID seems to increase with greater frequency of douching.
- The influence of hormonal contraceptives on acquisition and transmission of STIs/STDs is not fully known. However, several studies have found oral contraceptive use to be associated with an increased risk for acquiring chlamydia. At the same time, oral contraceptive use appears to decrease the likelihood of developing PID.
- People under the age of 30 tend to be more sexually active than people over thirty; they have sex more often, have more sexual partners, and use protection less consistently. The greater the number of sexual partners, the greater the risk of contracting an STI/STD for all individuals.
- Substance use, especially drugs and alcohol, are associated with greater risk at both the individual and the population level. On the individual level, substances can impact people's judgment and affect their choice of partner, the type of sexual behaviors in which they engage, and the appropriate use of barrier protection.

developed in recent years that can be performed on urine, cervical or vaginal specimens and that make detection of chlamydia easier and more reliable. Chlamydia can be easily treated and cured with antibiotics. Please go to **Section 5** of this document for more details.

How Can Chlamydia be Prevented?

This disease is easily prevented when young women and their sexual partners have the necessary knowledge and skills to take precautions or refrain from being sexual. In preventing chlamydia, it is important to have medically accurate information about the infection. It is also important to be aware of who is at risk, how it is transmitted, and how to avoid getting it or giving it to others. The surest way is to abstain from sexual contact, or to be in a long-term mutually monogamous relationship with a partner who has been tested and is known to be uninfected. Consistent and correct use of latex male condoms can substantially reduce the risk of transmission of chlamydia. Female condoms are also in important form of barrier protection.

Why Should I Care about Chlamydia?

Many people in Minnesota may think that the chlamydia epidemic does not affect them, particularly if they do not have teenage or young adult children. However all of us are impacted economically because health care costs go up when diseases such as chlamydia, that can be easily prevented, are allowed to escalate unchecked. In addition to the cost factor, as caring adults we have an ethical responsibility to prevent the unnecessary suffering that is experienced by young people who may not have sufficient or accurate information or the maturity and relationship negotiation skills to protect themselves from this silent disease.

To quote from the book *The Hidden Epidemic: Confronting Sexually Transmitted Diseases* published in 1997 by the Institute of Medicine, “Communities have a special responsibility to become involved because STDs and other communicable diseases threaten the health of the community at large, not just the infected individual. In addition, many of the underlying factors that contribute to the STD epidemic, such as lack of awareness, lack of access to healthcare, and unbalanced messages regarding sexual behavior, are most effectively addressed through community-based interventions” (pg. 223). *The Hidden Epidemic* goes on to say “...it is inappropriate to advocate that the STD epidemic be solved by individuals without the support of community interventions. It is the community’s responsibility to provide individuals with the support, information, and tools that are needed to prevent STDs. Many factors that are often beyond the control of the individual, especially socio-cultural factors, directly influence individual behavior and risk of STDs.”¹

Need for Advocacy

Teen and young adult females need a voice. A group whose sole mission is to advocate for the resources to improve the sexual health of young women, with a specific focus on reducing the epidemic rates of chlamydia, is needed in Minnesota. Until 2009, when the National Chlamydia Coalition was formed, there was no national organization addressing this pressing issue. The time has come for people who care about adolescents and young adults and who want to see rates of chlamydia reduced to begin advocating for health care solutions that will make a difference.

Chlamydia is More Than a Medical Problem

Public health efforts related to STIs/STDs have always concentrated on controlling infections. This has meant identifying people who are infected and seeing that they and their partners are treated, and that they do not transmit the infection(s) on to additional partners. As a result, public health funding has been narrowly directed at clinical programs that screen, test and treat patients in a medical setting. Primary prevention of STIs/STDs has been delegated to organizations that have the capacity to do primary prevention in coordination with their other work, e.g., pregnancy prevention and comprehensive sexuality education programs.

The World Health Organization (WHO) and several other international organizations have been leading efforts to direct energies related to STI/STD prevention and intervention toward the emerging arena of sexual health, with a foundation in the belief that sexual health is a basic human right.



The Minnesota Chlamydia Strategy: Action Plan to Reduce and Prevent Chlamydia in Minnesota

Minnesota Chlamydia Partnership, April 2011

Section 3: Reasons for Call to Action

The following summary of the chlamydia epidemic in Minnesota helped to inform the development of and setting priorities for the Minnesota Chlamydia Strategy.

The Incidence of Chlamydia in Minnesota

Chlamydia is the most frequently reported infectious disease in the United States and in Minnesota. The number of chlamydia cases in Minnesota has nearly tripled over the last 14 years, with a total of 15,294 cases reported in 2010 compared to 5,417 cases in 1996. Chlamydia infections are fairly evenly distributed throughout the state, with approximately one-third of the cases in 2010 reported in the urban areas of Minneapolis and Saint Paul, one-third reported in the seven-county suburban metro area surrounding the Twin Cities, and one-third of the cases reported in Greater Minnesota.

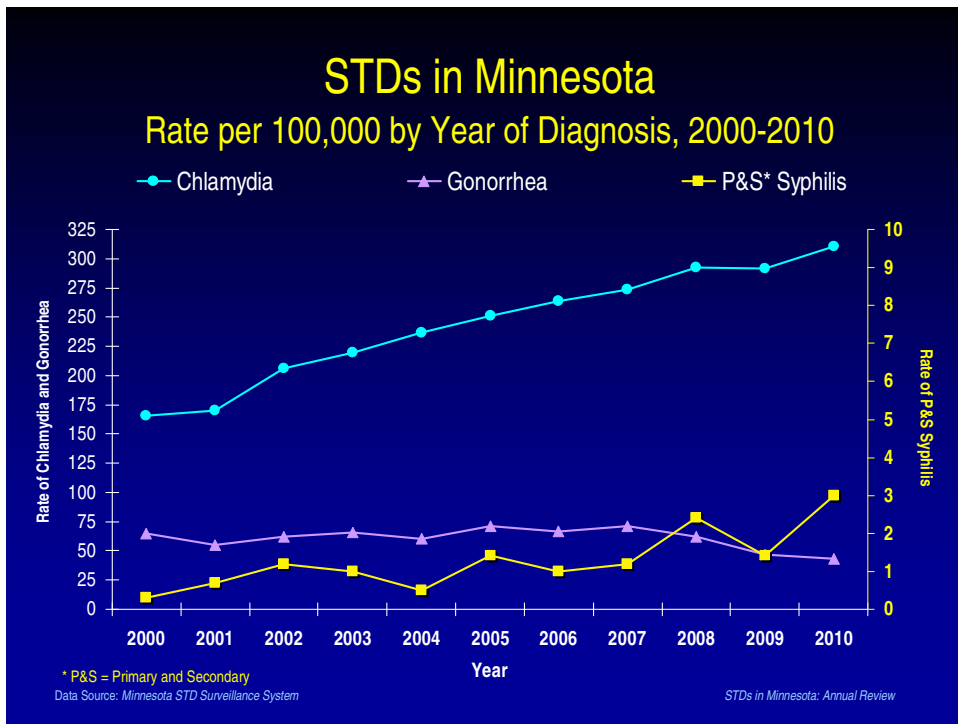
Youth, females and people of color are disproportionately impacted by chlamydia in Minnesota. Adolescents and young adults ages 15-24 account for the largest proportion of all cases that occurred in 2010. Seventy-five (75) percent of people infected in Minnesota are females and the majority of them are under age 25. The rate of chlamydia infection in 2010 among young Blacks ages 15-25 is 14 times higher than among Whites.

The actual number of people who are infected with chlamydia in Minnesota is unknown since a high number of people are asymptomatic; 75 percent of females and 50 percent of males with chlamydia are unaware of their infections because they have no symptoms and therefore do not seek testing. This results in many people not seeking medical treatment, allowing the disease to be spread to others and in 40 percent of infected females, to progress to serious and sometimes life-threatening consequences. Within three to six months following treatment, as many as 30 percent of females in certain geographic locations return to clinics with new infections.

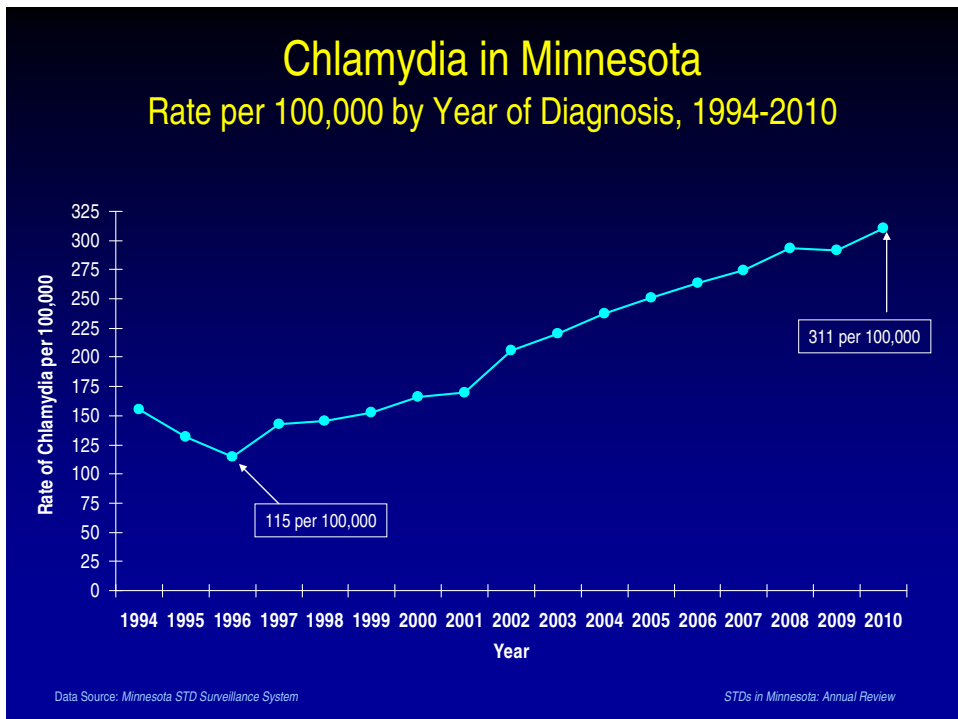
The charts on the following pages provide more details about the chlamydia epidemic in Minnesota. The last part of this section includes information from the 2010 Minnesota Student Survey about the sexual activity of 9th and 12th graders.

Chlamydia Is an Epidemic in Minnesota

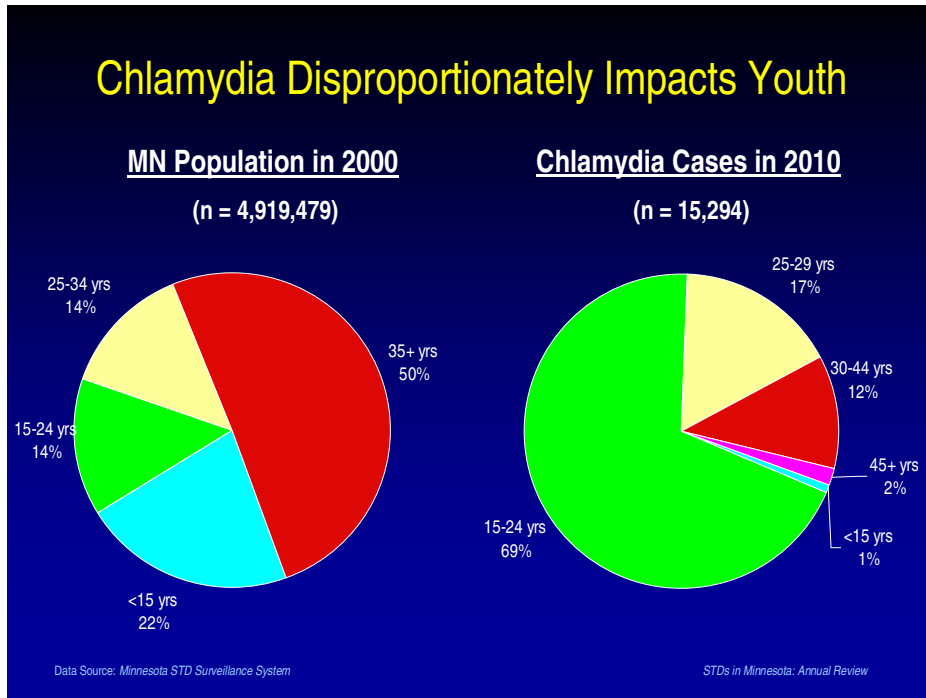
The number of people with chlamydia far exceeds the number of people with other STDs in Minnesota.



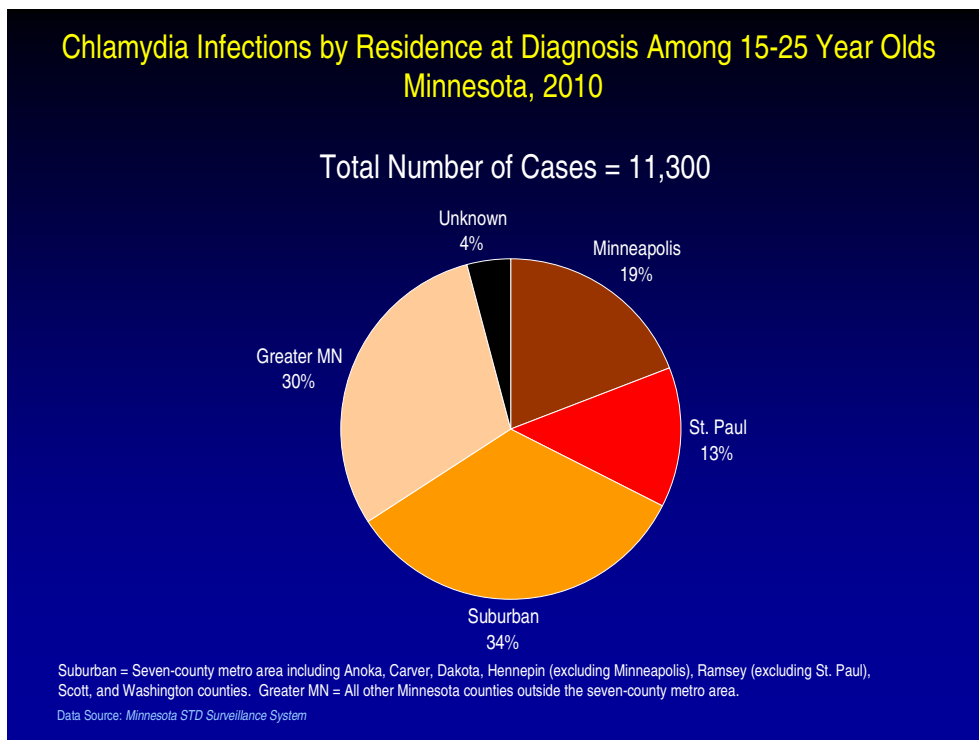
From an all-time low of 115 cases per 100,000 people in Minnesota in 1996, the incidence of chlamydia has almost tripled to 311 cases per 100,000 people in 2010.



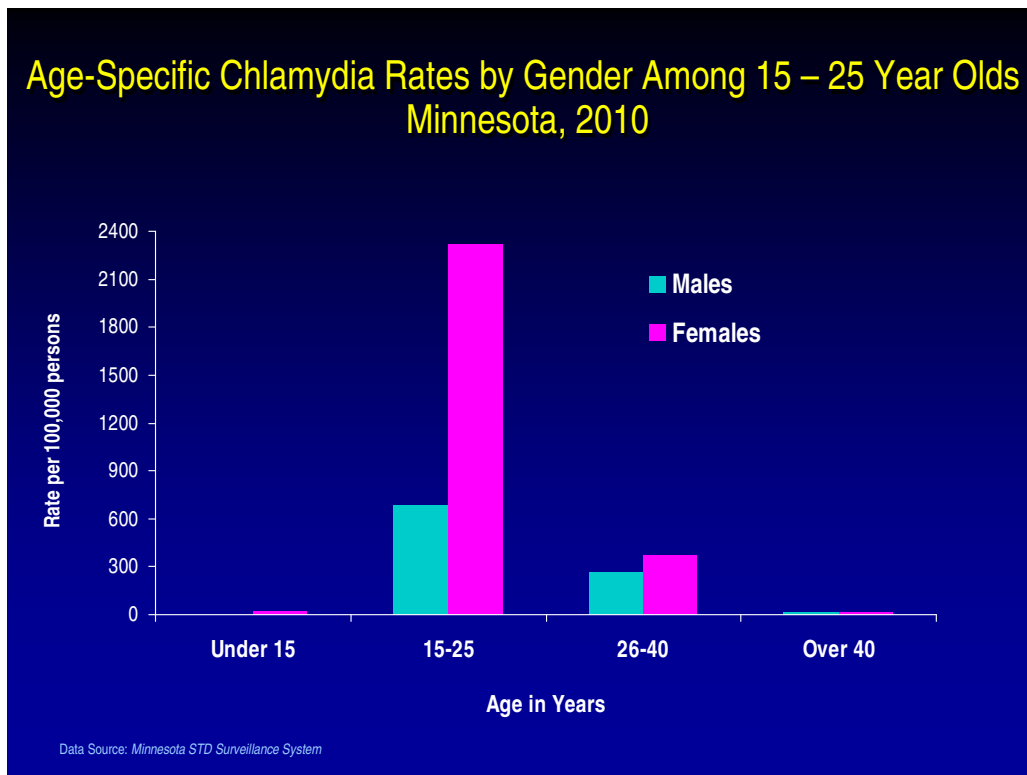
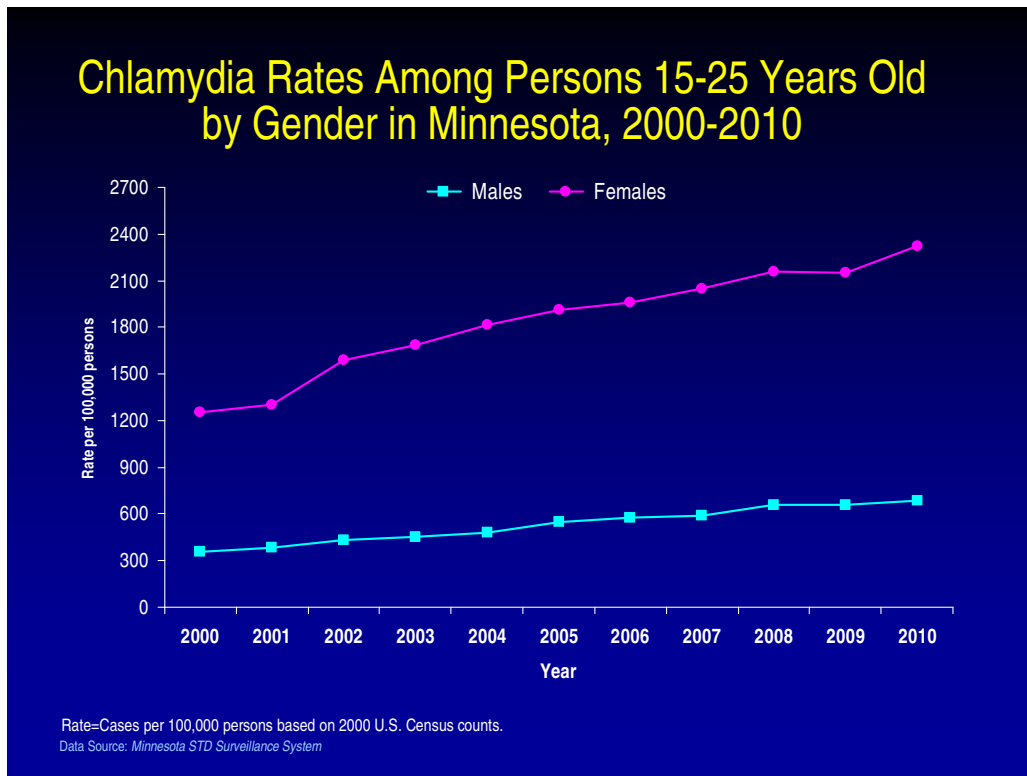
Chlamydia disproportionately affects youth in Minnesota, with adolescents and young adults ages 15-24 accounting for 69 percent of the cases that occurred in 2010.



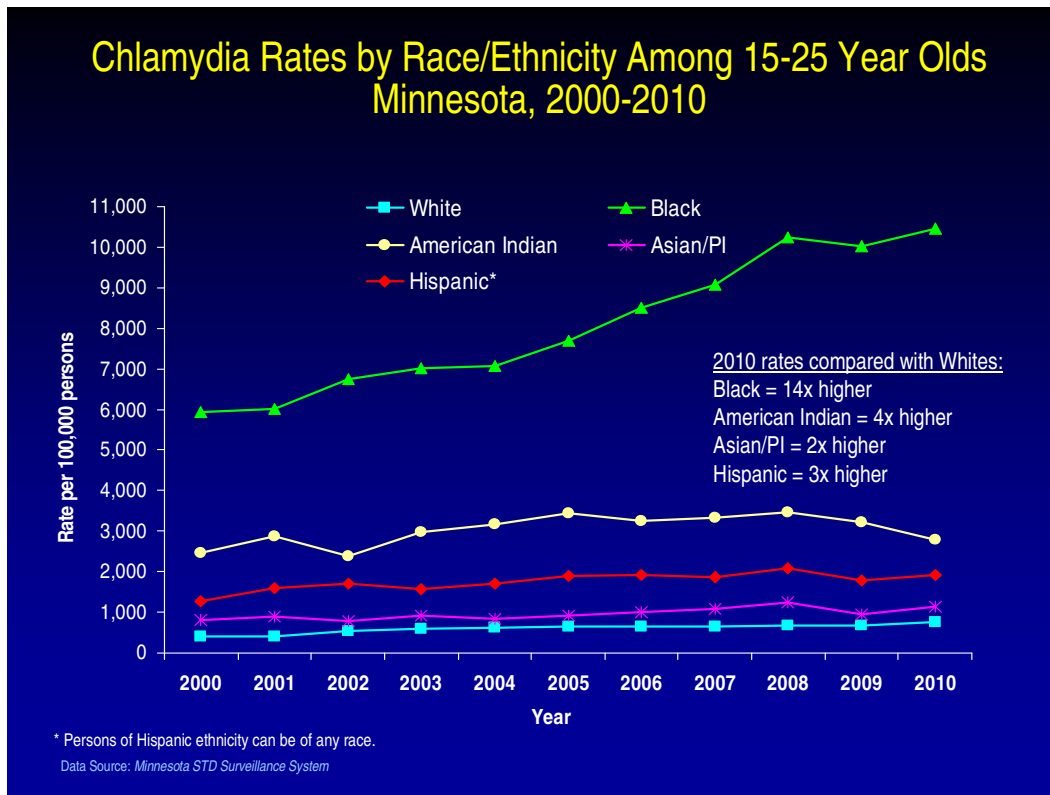
Chlamydia affects youth throughout the state of Minnesota.



Young females are disproportionately affected by chlamydia in Minnesota.



Youth of color are also disproportionately affected by chlamydia in Minnesota.



What about Gonorrhea?

Gonorrhea is another sexually transmitted disease that is often associated with chlamydia. While it would seem to make logical sense to address gonorrhea at the same time the MCP is addressing chlamydia, the number and locations of positive gonorrhea cases dictates a different response. Overall rates of gonorrhea in Minnesota are much lower than rates of chlamydia. In addition, the trend for gonorrhea rates indicates a reduction in the number of new cases since 2007. The number of cases of gonorrhea is substantially less than for chlamydia: 1,468 in ages 15-25 compared to 11,300 cases of chlamydia in 2010. For these reasons, MDH recommended that the efforts of the statewide coalition focus on chlamydia only. Some tactics proposed in the Strategy will simultaneously address gonorrhea and other efforts at MDH will focus on reducing the rates of gonorrhea.

Additional information about STI/STD rates in Minnesota can be found at:

<http://www.health.state.mn.us/divs/idepc/dtopics/stds/stats/stdsurvrpts.html>

or by contacting Dawn Ginzl at 651-201-4041 / dawn.ginzl@state.mn.us

Reasons for the Increase in Chlamydia

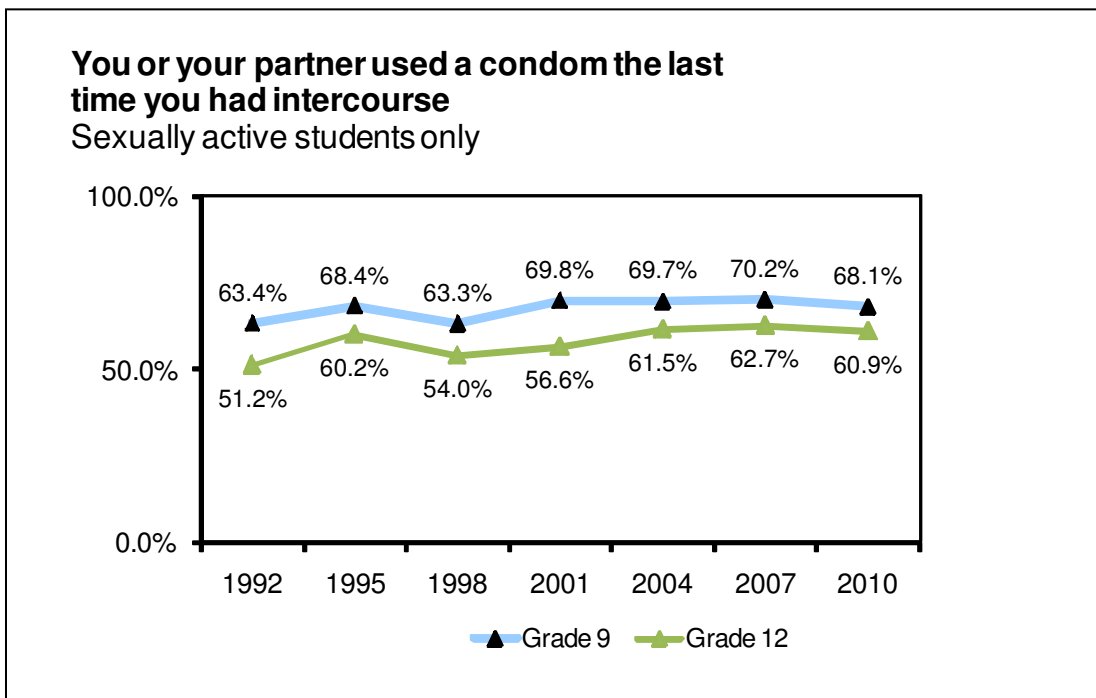
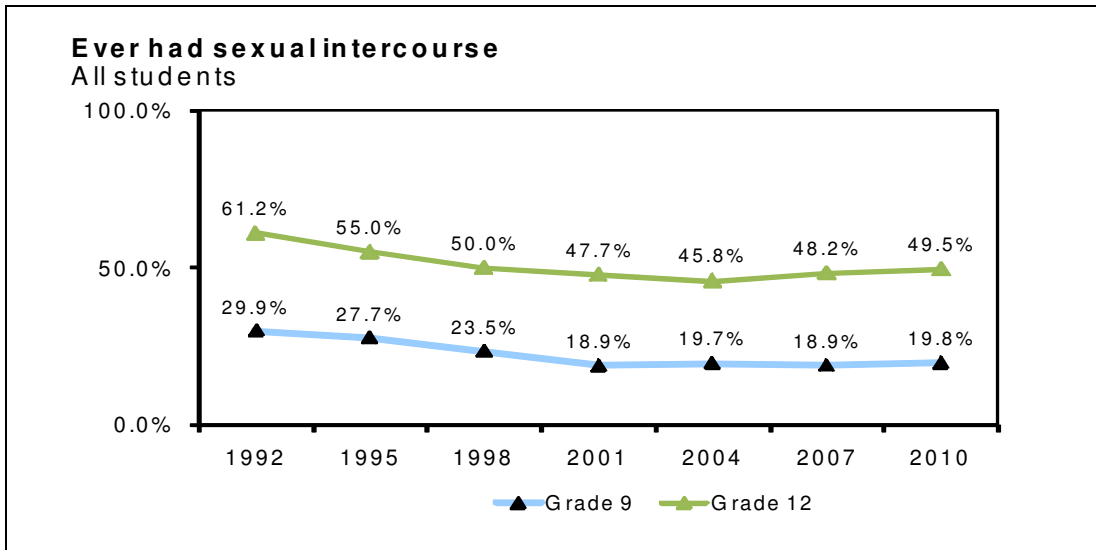
There are several factors that have contributed to the increases in chlamydia seen over the past 14 years: the rate of screening for young females has increased, newer laboratory tests that are more sensitive and more specific are being used, and there is better reporting of positive cases to MDH. However, the effect of these factors should have leveled off over time. Since that is not the case in Minnesota, as well as the rest of the country, the other reason for the increase appears to be that there is more disease in the population.

Sexual Activity Among Youth in Minnesota

Since chlamydia is transmitted by unprotected vaginal, anal and oral sex, research on rates of sexual activity in adolescents and young adults provides additional insight. The following statistics are from the 2010 Minnesota Student Survey, a survey that is administered every three years to 6th, 9th, and 12th grade students. Only data for 9th and 12th graders are included here. Participation in the survey is voluntary, anonymous, and confidential.

Sexual Activity and Condom Use

Results from the survey indicate that 12th graders were more likely to have ever had sex but less likely to have used a condom at the time of last intercourse.



Sexual Activity by Region in Minnesota

The results of the survey indicate that rates of sexual activity are comparable across the state and not focused in certain geographical areas.

Have you ever had sexual intercourse (had sex)?				
Region	9 th Grade		12 th Grade	
	Male (%)	Female (%)	Male (%)	Female (%)
East Central	20	18	51	54
Metro	22	17	49	47
Northeast	24	21	60	59
Northwest	26	24	56	58
Southeast	21	18	53	51
SW/South Central	21	17	53	54
West Central	22	19	53	53

The last time you had sexual intercourse, did you or your partner use a condom?				
Region	9 th Grade		12 th Grade	
	Male (%)	Female (%)	Male (%)	Female (%)
East Central	70	70	62	54
Metro	72	64	65	59
Northeast	74	66	61	53
Northwest	71	64	65	52
Southeast	75	66	67	58
SW/South Central	75	63	64	58
West Central	68	58	68	58

More data from the Minnesota Student Survey can be found at:

<http://www.health.state.mn.us/divs/chs/mss/>



The Minnesota Chlamydia Strategy: Action Plan to Reduce and Prevent Chlamydia in Minnesota Minnesota Chlamydia Partnership, April 2011

Section 4: The Impact of Chlamydia

Health Consequences

The general public is largely unaware of the health consequences of chlamydia for four main reasons:

- 1) Chlamydia is asymptomatic and often goes undetected.
- 2) A major health consequence such as infertility occurs years after the initial infection, making it more difficult for people to make the link to an infection experienced years earlier.
- 3) The stigma associated with having any STI/STD has inhibited public discussion and health education about the various diseases and in some cases, even prevents health care professionals and educators from providing the information and skills necessary for young people to protect themselves from disease – information and skills that are applicable for the rest of their lives.
- 4) There has been no advocacy group to speak up for the needs of adolescent and young adult females that have experienced sex and are or may be infected with chlamydia.

Complications from chlamydia, as with most STIs/STDs, are greater and more frequent among women than men, representing a serious health threat to the reproductive capacity of individuals and couples. A variety of short-term and long-term health problems for women all result from unrecognized or untreated STIs/STDs, especially chlamydia.

Short-term reproductive health consequences for women include PID and complications during pregnancy. Up to 40 percent of women with untreated chlamydia will develop PID and, in some cases, may need to be hospitalized. In addition, pregnant women can infect their babies during the birthing process. This can result in eye infections and pneumonia, causing stress and expense for families. Symptoms of urethritis and epididymitis in men tend to show up within a short time after chlamydia is contracted, resulting in males seeking diagnosis and treatment much sooner than females.

Long-term reproductive health consequences for women include ectopic pregnancy, infertility and chronic pelvic pain. Ectopic pregnancy affects approximately 9 percent of women with PID and can be life-threatening. Of those with PID, 20 percent will become infertile; males can experience infertility as well although it is rare. Eighteen (18) percent of women with PID will experience debilitating and chronic pelvic pain which can affect them for the rest of their lives, long past their reproductive years. The rates of infertility in the U.S. have risen dramatically over the past several decades. It is unknown how much undiagnosed chlamydia has contributed to this trend.

Additional Risks

The more times that a female contracts chlamydia, the greater the likelihood that she will experience the serious consequences listed above. People are often re-infected by having sex with partners who have not been screened or treated.

Chlamydia causes inflammation in the genital area and reproductive organs, making it easier to contract and transmit the HIV virus if it is present during sex.

Disparities in Communities of Color

Certain racial and ethnic groups (mainly African Americans and Hispanics) have high rates of STIs/STDs, compared with rates for whites. There are no biological characteristics related to being African American or Hispanic that makes one more susceptible to becoming infected with an STI/STD. Chlamydia is an equal-opportunity infection that affects people of all ages, all races and ethnic groups, all sexual orientations, and those living in any location. However, there are other factors at work that can increase the risk of acquiring or transmitting chlamydia.

A study done in the Twin Cities urban area in 2010 by the Wilder foundation and funded by Blue Cross Blue Shield revealed that, “In general, we see the same pattern with health that we do for other measures of well-being, including educational attainment, poverty and income, employment, and rates of home ownership: As a group, people of color fare worse than do whites in our region on a variety of health measures including birth weights, obesity, diabetes and mortality.”² The report also found that Asian, Latino and African-born populations have better health outcomes than non-Hispanic whites, American Indians, and U.S.-born blacks in our region.

The Wilder report supported other studies done in the U. S. and other countries that demonstrated how higher socioeconomic status coincided with improved health outcomes. Health has been shown to be connected to the socioeconomic condition and relative prosperity of the neighborhoods in which people live. In particular, poverty and economic inequality have been found to be associated with high rates of sexual activity, pregnancy, premarital births, abortions and resistance to contraceptive use in adolescents. A few studies have examined the association between community characteristics and STI/STD infection rates among adolescents. These studies suggest that disadvantaged communities have higher STI/STD rates.

Frequently people of color are impacted by fundamental, community-level factors that determine health status, such as poverty, limited or no access to high quality, culturally-competent health care, lack of health insurance, homelessness, limited transportation and community disorganization.

Economic Impact

Costs Related to Chlamydia in the United States

STIs/STDs are a tremendous health and economic burden on the people of the U.S. Several research studies have examined the existing literature on STI/STD costs to estimate the lifetime medical cost per case of several major STIs/STDs, including chlamydia. In *Sexually Transmitted Diseases in America: How Many Cases and at What Cost?*, a report prepared by the American Social Health Association (ASHA) for the Kaiser Family Foundation in 1998, the total estimated burden of the nine million cases of eight major STIs/STDs that occurred among 14-24 year-olds in 2000 was \$6.5 million. About 6 percent of that amount was attributable to non-viral STIs/STDs.³ Another study states that untreated chlamydia can cost society over \$3.1 billion annually.⁴

It is useful to look at the costs for treating bacterial and viral STIs/STDs separately because the nature of these infections is quite different. Treatment of bacterial STIs/STDs usually results in a cure and the therapy is short and relatively inexpensive. In addition, by far the greatest costs associated with bacterial STIs/STDs result from complications of untreated chlamydia and gonorrhea, particularly PID. Assessing the economic burden of STIs/STDs is important for two reasons. First, estimates of the cost of treating STIs/STDs among adolescents and young adults can help quantify the impact of STIs/STDs on the nation’s youth and on those who pay for their medical care. In many cases, the payers are publically

funded programs. Second, routine economic impact assessments (cost-effectiveness and cost-benefit analyses) of chlamydia screening programs, interventions and prevention programs are critical for making decisions related to health policies. The National Commission on Prevention Priorities ranks the screening of females ages 25 years and under as one of the 10 most beneficial and cost-effective prevention services, but it is also among the most underutilized.⁵

Direct and Indirect Costs

The economic impact of STIs/STDs includes direct, indirect and intangible costs. Direct cost refers to expenditures for health care and includes the value of goods and services that were actually used to diagnose and treat STIs/STDs and their sequelae. These direct expenditures may either be for medical or non-medical services and materials. Examples of direct medical costs include the cost of clinician visits, hospitalization, diagnostic testing, drug treatments and therapeutic approaches. Other direct, non-medical costs associated with receiving medical care or prevention services include the cost of transportation or educational materials. Indirect cost refers to lost productivity and lost wages attributable to STD-related illness and any associated disability. It also includes lost wages due to premature death.

Intangible Costs

Intangible costs are related to the pain and suffering associated with STIs/STDs. The ASHA panel, in the Kaiser report, noted that STIs/STDs have a high human cost in terms of pain, suffering and grief for people experiencing short-term and long-term consequences. This impact cannot be measured in dollars.⁶

It is impossible to measure the grief that comes from an ectopic pregnancy that takes a woman from the excitement of finding out she is pregnant to the heartbreak of miscarriage within a few hours. Or the emotional pain women and couples experience as a result of finding out they will not be able to have the children they always wanted. In addition, couples in these situations often experience strain in their relationships.

Another complication from untreated chlamydia that can have profound affects on the quality of a woman's life can be chronic pelvic pain. It can be difficult to assess the source and exact location of pelvic pain, often resulting in multiple doctors' office visits and the expense of multiple diagnostic tests and procedures. Pelvic pain is the number one reason why women visit their gynecologist.

Unlike most other diseases, STIs/STDs often cause stigma and feelings of shame and embarrassment in people who are infected and can also have a dramatic impact on relationships. In a 1998 Kaiser Family Foundation/Glamour Magazine study of adults, 44 percent of men and 47 percent of women said if they were in a new relationship and discovered their partner had an STI/STD, they would be "a lot less likely" to continue the relationship, with another third saying they would be "somewhat less likely" (30 percent men, 29 percent women). Most say they would feel angry at the person they got it from if they found out they had an STI/STD, though women (87 percent) are more likely than men (74 percent) to say so.⁷ Confronting and diminishing the shame and stigma related to chlamydia is a goal of the MCP.

Estimated Costs Specific to Minnesota

It should be noted here that actual comprehensive data for the U.S, as well as for individual states, on STI/STD incidence and cost do not exist. There has never been an analysis of the costs of chlamydia specific to Minnesota. This is an area that needs more research and analysis by health economists, a recommendation that was made by workgroups that worked on the Minnesota Chlamydia Strategy. In lieu of that data, and in order to provide a snapshot of costs that will allow preliminary discussions, we are referring to data presented in three articles published in the journal *Sexually Transmitted Diseases* in recent years.

One study, published in 2010, used data from private insurance claims available for 2003-2007 to estimate the direct cost of chlamydial infections.⁸ These researchers estimated the direct costs at \$108 per episode of chlamydia, including outpatient costs and medications. Obviously this average amount can vary based on any number of factors, and it does not include indirect costs. It also does not include costs associated with public health follow-up of untreated cases or partners.

Another study published in 2004 looked at the average cost per case of chlamydia, based on costs of diagnosis and treatment of acute infections, screening tests that yielded positive test results and sequelae resulting from untreated acute infections or from delayed or improper treatment.

Authors estimated that the average cost of diagnosing and treating an acute case of chlamydia at \$73 per case. This average reflects testing and treatment for males and females provided in a variety of settings and utilizing single dose therapy. The average cost of treating sequelae resulting from acute infections in males was a low of \$144 per case to treat epididymitis and a conservative estimate of \$1,334 per case of PID in women. When looking at the combined costs, the authors found that 82 percent of the estimated costs per case for women are attributable to sequelae (e.g., PID, ectopic pregnancy, and chronic pelvic pain) while 78 percent of the estimated cost per case in men was attributable to acute infection. The expected cost per case of chlamydia in males is \$20 and the expected cost per case of chlamydia in females is \$244. This includes estimated costs of diagnostic testing and single dose treatment as well as an estimated average cost to treat epididymitis in males and PID in females.⁹

Estimated Annual Cost of Chlamydia in Minnesota

In 2010, there were 4,327 males and 10,965 females reported with chlamydia in Minnesota. Using \$20 per male and \$244 per female, it can be estimated that the cost of diagnosing and treating chlamydia in 2010 in Minnesota was **\$2,762,000**.

These estimated lifetime costs per case are subject to considerable uncertainty and should be viewed as ballpark figures rather than precise calculations.

A third study published in 2006 attempted to estimate the productivity losses associated with untreated chlamydia in reproductive-age women. The results indicated that the average productivity loss per untreated chlamydia infection was approximately \$130. The average productivity loss per case of acute PID was estimated at \$649. These losses were highly correlated with age which is understandable since the women in the age groups with the greatest likelihood of having an untreated chlamydia infection and to experience serious sequelae were less likely than older women to be employed in the paid labor force, to be employed in well-paying jobs, or to work full-time. The researchers did not take into consideration the productivity losses of women who were not in the paid labor force but do acknowledge lost production occurs in areas such as child and elder care, and household management.¹⁰

Funding Needed to Support Chlamydia Activities in Minnesota

It is not possible, without a formal cost analysis, to accurately determine the exact amount of funds that are needed to diagnose and treat chlamydia per year in Minnesota. To determine that amount, we would need to know how many people are tested in addition to how many of those people are positive. At this point in time, there is no centralized mechanism for determining those numbers. As stated earlier, the only data collected by the MDH surveillance system is the number of people who were diagnosed with chlamydia and reported in any given year. For the purposes of assessing what amount of funding is needed to cover the costs of screening and treating chlamydia, a formal cost analysis study is needed.



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Section 5: Screening, Treating and Reporting Chlamydia

While the information in this section is particularly pertinent to health care providers, it is valuable for everyone to understand the importance of chlamydia screening and treatment so that we can each make informed decisions about our personal health care.

Screening Recommendations

The CDC updated its guidelines for the screening and treatment of persons who have or are at risk for STDs after consultation with a group of professionals in the field of STDs who met in Atlanta on April, 2009. The new guidelines update the *2006 Guidelines for Treatment of Sexually Transmitted Diseases (MMWR 2006;55[No. RR-11])*.

2010 CDC Recommendations for Chlamydia Screening

- Screen all sexually active females 25 years old and younger for chlamydia infection annually.
- Sexually active females age 26 and over who have a greater risk of infection due to one or more of the following risk factors should also be screened:
 - History of a sexually transmitted infection
 - New or more than one sexual partner
 - African American race
 - Cervical ectopy (an inflammation or erosion of cells on the cervix)
 - Inconsistent use of barrier contraceptives, especially condoms

These recommendations are supported by:

- American Academy of Family Physicians
- American Academy of Pediatrics
- American College of Preventive Medicine
- American College of Obstetricians and Gynecologists
- American Medical Association
- The Society of Adolescent Health and Medicine
- U. S. Preventive Services Task Force
- The National Infertility Prevention Project
- The Minnesota Department of Health
- Institute for Clinical Systems Improvement

In addition, chlamydia screening in women is currently recommended as one of the standards to be evaluated in the Minnesota Community Measurement Program. Effective January 1, 2010, all physician clinics in Minnesota are required to submit data on measures to be publicly reported to the Commissioner of Health, under Minnesota Statutes 62U.02. Minnesota Community Measurement

(MNCM) is collecting this information for the Minnesota Department of Health (MDH). Further information can be found at <http://www.mncm.org/site/>.

The Importance of Screening and Treatment

Screening of young women who are sexually active and are not symptomatic is extremely important so that cases can be diagnosed and treated, thus preventing serious consequences and saving health care dollars. Screening females aged 25 years old and under is ranked by the National Commission on Prevention Priorities as one of the ten most beneficial and cost-effective prevention services, but it is also among the most underutilized.¹¹ Screening coverage increased during 2001-2009 but still was less than 60 percent; in 2009, coverage was 43 percent among eligible females enrolled in commercial health-care plans and 57 percent among the Medicaid population. Expanding chlamydia screening is critical to reducing disease burden and the accompanying complications.

Screening means that any young woman under age 26 who comes into a clinic for any reason and is sexually active should be offered a chlamydia test. An appropriate sexual risk assessment by a health care provider should always be conducted and may indicate more frequent screening for some women.



Routine screening done at the time of an office visit, regardless of the reason for the visit, is the only way to reliably identify people who are infected but have no symptoms. Following infection and treatment, people do not develop immunity that prevents them from getting chlamydia again. Therefore, screening needs to be repeated for young people who continue to be sexually active and do not use protection.

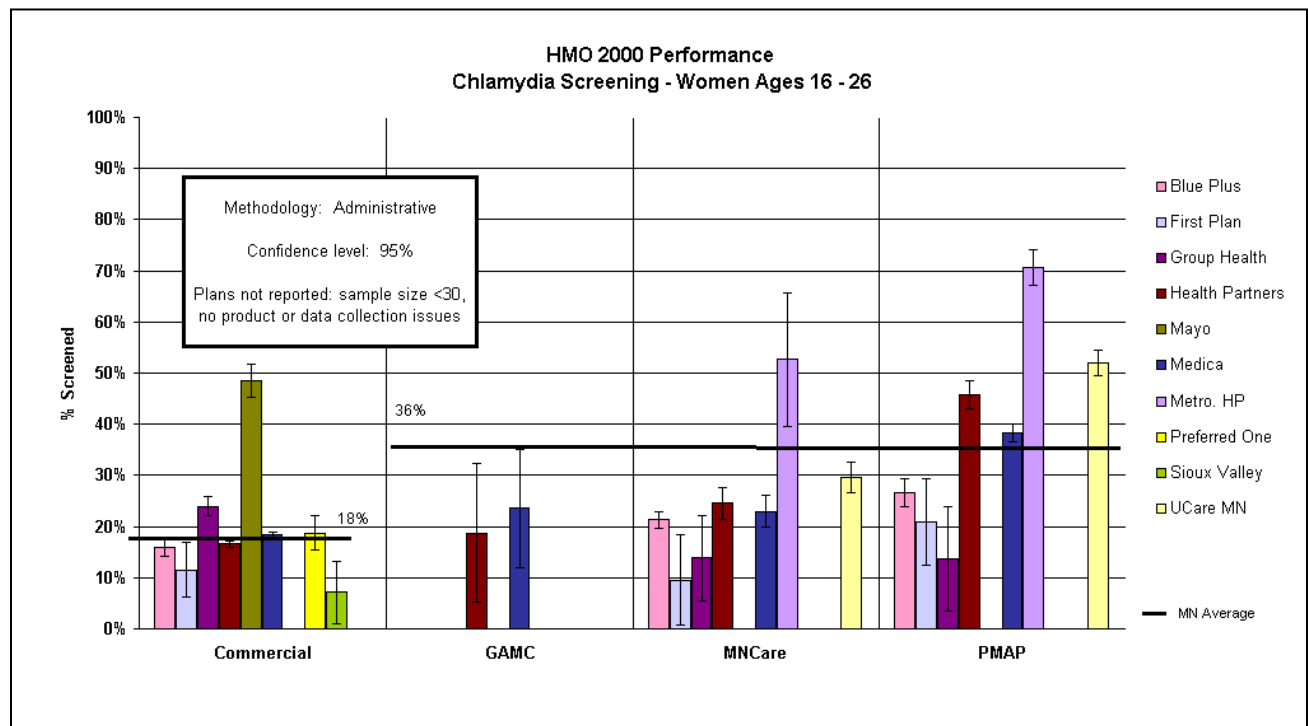
Data from a randomized controlled trial of chlamydia screening in a managed care setting suggest that screening programs can lead to a reduction in the incidence of PID by as much as 60 percent.¹² These data, combined with the asymptomatic nature of chlamydial infections, make routine screening in a variety of clinical and non-clinical settings the cornerstone of effective chlamydia prevention and control.

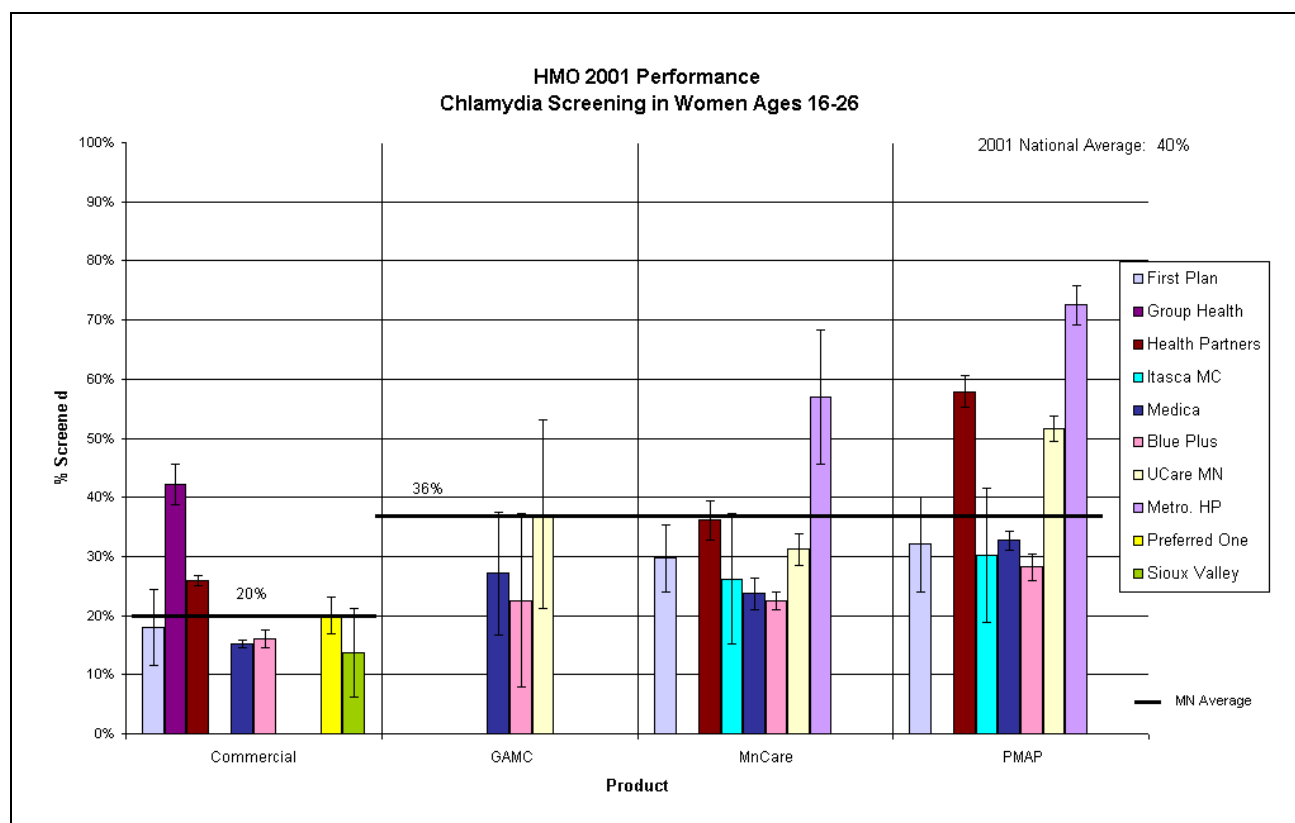
Rates of Screening

The CDC and the U.S. Preventive Services Task Force recommend screening sexually active women ages 15-25. In spite of that, there are still a considerable number of women in that age group who are not tested every year.

Annual chlamydia screening rates have been reported by commercial and Medicaid plans to the Healthcare Effectiveness Data and Information Set (HEDIS) since 1999. This became part of the mandated list of reporting requirements in 2010. Data from the 2002 HEDIS indicate that the percentage of young, sexually active women ages 16-20 seen in commercial managed care settings who are screened is even lower (27 percent) than estimates for the whole population of the U.S.¹³

Some Minnesota managed care organizations did a better job during the same time frame. The results are reflected in the tables below. These tables reflect estimates of the percentage of women ages 16-26 who identified as sexually active and had at least one chlamydia test in an HMO in Minnesota during 2000 and 2001.¹⁴





There are numerous reasons why the numbers of women screened for chlamydia vary so greatly. They include health care providers' lack of knowledge about chlamydia and screening guidelines, lack of comfort talking about sexuality, or assumptions that their patients are not at risk. Patients, particularly younger patients, may experience fear of testing and getting the results, as well as barriers to accessing services. In addition, the emphasis on screening in publically-funded programs may tip the balance when comparing higher rates of screening in those clinics to lower rates in managed care settings.

It is also important to restate here that when the numbers of people who are screened go up, more people will be diagnosed with chlamydia and that will cause rates of infection to go up. Until more people are diagnosed and then treated, we will not be able to bring the rates down. When this occurs, it should not be assumed that screening and treatment are not working. In fact, it will mean that it is effective. With rates as high as they are now, and with so much that remains to be done to adequately address the problem, it will be some time before we can expect a reduction in numbers of cases.

Access to Screening and Treatment

Screening and treatment for chlamydia are the most important tools for reducing rates of infections but are only useful when they are accessible and affordable to the people in need of them. Since 1993, the National Infertility Prevention Project has made great strides in expanding chlamydia screening to young women in public sector settings. However there are numerous barriers to adolescent and young adult patients having easy access to screening and treatment programs that are affordable for them.

What About Screening for Males?

Twenty-five (25) percent of people reported as positive for chlamydia in Minnesota are male and the majority are under age 26. It seems logical to provide screening to males since the majority of females who are contracting chlamydia are having unprotected sex with males. However, CDC released the following statement in 2004, "In general, screening of asymptomatic men is not cost-effective unless the prevalence in the men screened is substantially higher than the prevalence in the women who can be screened." With scarce resources, clinics are encouraged to follow this guideline and look for opportunities to screen greater numbers of women.

Fewer males than females experience symptoms (about 50 percent) but when they do, they tend to go into a clinic for testing. In addition, since fewer men experience symptoms, it is possible that their bodies are able to more effectively fight off the infection than women, although the biological reasons for this are not clear. Complications tend to be much less frequent and less severe in males so the cost to treat them is much lower. Because women are more often asymptomatic than men and experience complications much more often than men, it makes sense to dedicate more resources to screening women.

CDC Screening Guidelines for Males

CDC has recommended screening men in the following situations:

- Men seen in STD clinics
- Men participating in Job Corps
- Men under age 30 entering correctional facilities

Men should also be re-screened three to six months following treatment for chlamydia.

For a report on a CDC consultation that explored the need for screening males, go to the CDC Web site at: <http://www.cdc.gov/std/chlamydia/ChlamydiaScreening-males.pdf>

Since screening programs for men are limited, improved strategies for identifying and assuring that partners are treated could help reduce the high rate of infection and re-infection and related complications for women's health and fertility.

Diagnosing Chlamydia

In females, chlamydia infection can be diagnosed by testing urine or cervical or vaginal swab specimens in a laboratory that is qualified to perform those tests. The CDC recommends collecting vaginal swabs on females and urine specimens on males. The types of tests currently used most frequently are called nucleic acid amplification tests (NAATS), and they can identify chlamydia by determining that the specimens submitted contain the DNA specific to chlamydia. The newest tests are also more reliable since they need only one copy of the chlamydia DNA in order to say that chlamydia is causing the infection.

Screening means providing a specimen for testing in a lab even though the person submitting the specimen is not experiencing any symptoms. Testing that is performed when patients complain of symptoms is referred to as *diagnostic testing* because there is reason to believe there is a problem and so a diagnosis is sought. Diagnostic testing can also be done when individuals know that one of their sexual partners has been diagnosed with chlamydia or they have reason to believe they might have been exposed.

According to a study published by the CDC in 2009, only 41.67 percent of sexually active women ages 16-25 were screened across the country in 2007. This is a sizeable increase over the rate of 25.3 percent that were screened in 2000. However screening rates are still remarkably low when less than half of the women eligible for screening actually were tested.¹⁵

Until recently, most females have been encouraged to have an annual pelvic exam in order to have a Papanicolaou test (PAP test) done to screen for cervical cancer. A specimen that can be tested for chlamydia is often collected at the same time. Interestingly, the article noted above reported that 79.9 percent of those young women received a PAP test in 2007, meaning that chlamydia screening rates remain substantially lower than other critical women's health services such as PAP tests.

Also, there is a concern that since the American College of Obstetricians and Gynecologists (ACOG) changed their recommendation for PAP tests in November 2009 to say that women do not need yearly PAP tests until age 21 and then every two years rather than every year, there will be even less screening for chlamydia. This is compounded by another recommendation that pelvic exams should not be required before women can receive contraceptives, thus eliminating another opportunity for chlamydia screening.

All of these situations mean that routine screening annually, or whenever a young woman enters a doctor's office will become even more necessary.

Treatment

Treatment for uncomplicated cases of chlamydia in men and in women who are not pregnant consists of taking a one gram dose of the antibiotic azithromycin or 100 milligrams of the antibiotic doxycycline taken two times a day for seven days. (See 2010 CDC STD Treatment Guidelines at <http://www.cdc.gov/std/treatment/2010/default.htm>).

People taking these antibiotics seldom have adverse reactions. While a single dose of azithromycin is more expensive than doxycycline, it may be easier for patients to comply with taking one dose as opposed to remembering to take two doses a day for a week. It is also important that people who are positive do not have sex within seven days following treatment.

Patients who go to a clinic because they have symptoms or are concerned they might be infected are sometimes treated without being tested first. This is because the wait time between the time someone is tested and results are received by the clinic can vary from 24 hours to three days. Rather than waiting for test results in cases where the likelihood of infection seems to be high, patients are treated presumptively in order to insure treatment and reduce the possibility of transmission.

Partners are Patients Too – Partner Management Strategies

Women and men who are told they have an STI/STD and are treated for it should notify all of their recent sex partners (sex partners within the preceding 60 days) so they can see a health care provider and be evaluated for STIs/STDs. Sexual activity should not resume until all sex partners have been examined and, if necessary, treated.

Treatment of sexual partners is important because women are frequently re-infected if their partners are not treated. Another essential tool for reducing rates of chlamydial infections is partner notification. Whenever possible, health care providers encourage patients who are diagnosed with chlamydia to

bring their partners into the clinic to be tested and treated. There are many situations when this is not possible or reasonable. In cases where patients are unable or unwilling to contact their partners and notify them they have been exposed to chlamydia, the MDH Partner Services staff can help. Patients can contact the STD and HIV Section Partner Services Program by calling 651-201-5414.

Providers also have a new tool, Expedited Partner Therapy (EPT), that was approved by the Minnesota state legislature in 2008. This allows health care providers with prescribing privileges to prescribe medications to treat chlamydia and gonorrhea, following the CDC treatment guidelines, for partners of patients who test positive without seeing the partners in person. Medications may be given to patients for them to give to their partners or a prescription may be provided, requiring the partner to go to a pharmacy to have it filled. EPT is indicated for partners who are unable or unlikely to seek timely medical attention. Clinical assessment by providers is still the preferred way to treat partners, but EPT is available in situations in which partners would not receive treatment without it. There is research to show that when more partners get treated, the rates of infections and re-infections decrease. More information on EPT in Minnesota is available at www.health.state.mn.us/ept.



In the event an infected person does not return to the clinic where they were tested to get their results, and the clinic is not successful in contacting them within a short period of time so they can come in for treatment, staff from the MDH Partner Services Program are informed and will attempt to ensure that they are treated and that their partners are treated. It is important for patients, partners and providers to understand that the MDH Partner Services Program is not able to contact partners for every person who is positive for chlamydia.

Re-screening

Studies have shown that from 10-30 percent of women who are re-screened four to 12 weeks following completion of treatment are positive for chlamydia again. The CDC recommends that all women be re-screened three to four months after completing treatment. If re-screening is not possible then, women should be re-screened at the time of their next office visit. The goal of re-screening is to look for re-infection, not to assess the effectiveness of treatment since treatment failure rates are extremely low when the recommended treatments are used.

Reporting Chlamydia

Chlamydia is one of six STIs/STDs that health care providers and laboratories are required to report in Minnesota. According to the Minnesota Communicable Disease Reporting Rule, health care providers are required to report cases with confirmed laboratory results within one working day to the MDH. Physicians who have reason to believe that a person having chlamydia has not completed therapy are required to notify the MDH immediately and provide that person's name, address and other pertinent information so the MDH can follow up; this also applies to people who refuse treatment. Physicians are strongly encouraged to also provide the names and addresses of sexual partners that might be infected to the MDH so Partner Services staff may follow up.

A full copy of the rules (Minnesota Rules, part 4605.7030-7040) is accessible at <http://www.health.state.mn.us/divs/idepc/dtopics/stds/rulestds.html>.

MDH Partner Services staff attempt to contact patients that have not yet been treated and any sexual partners that are identified by patients. Timely reporting allows for efficient follow up and treatment of these patients and their partners thus breaking the chain of transmission.

Understanding What the Numbers Mean

The data supplied by the MDH on the numbers of people infected with STIs/STDs are based on the reports of positive test results reported to MDH. The term surveillance refers to the systematic collection of data that are used to monitor the frequency and distribution of STIs/STDs in the population. Surveillance data are used to monitor trends such as increases and decreases, help MDH staff prioritize resources, develop and target programs designed to intervene in the disease process, and evaluate the effectiveness of these interventions. It is important to understand who the statistic is for, what the statistic is measuring, and what the time frame is for the measurement. It is especially important to keep these guidelines in mind when reading and interpreting statistics, especially since it is difficult to definitively interpret what data means when the numbers are small.

Increases and decrease in STI/STD rates can be due to actual changes in the occurrence of disease and/or to one or more of the following factors:

- How many people in Minnesota sought testing
- How sensitive the diagnostic tests are
- How effective providers and laboratories are at submitting case report forms.

All of these things impact the statistics and so it is helpful, when attempting to interpret what these numbers mean, to seek the assistance of someone who works with these numbers frequently. The MDH STD Surveillance Coordinator, Dawn Ginzl, is available to assist and can be reached at 651-201-4041 or dawn.ginzl@state.mn.us.



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Section 6: Addressing Chlamydia in the U.S. and Minnesota

National Infertility Prevention Project

In 1993, Congress appropriated funds to support the development of the Infertility Prevention Project (IPP) to prevent infertility resulting from untreated chlamydia. Through a cooperative effort between the CDC and the Office of Population Affairs (OPA), the program now funds chlamydia and gonorrhea screening and treatment services for low-income, sexually active women attending family planning, STD and other women's healthcare clinics. In addition, participating clinics submit data on clients tested that helps CDC track the prevalence of chlamydia and gonorrhea and to monitor trends. Key partners include: state and local STI/STD programs, usually managed by state health departments; family planning programs including Title X programs; the Indian Health Service's national STD prevention program; family planning regional training centers; and, state public health laboratories. This program has shown that routine screening of women can reduce chlamydia prevalence and PID incidence in women.

Title X refers to the federally funded program that provides reproductive health care to low-income women. In many situations and locations, Title X programs are the only medical providers available to a portion of the women served and, as a result, additional health care services are provided.

Since the inception of the IPP, there has been substantial expansion of chlamydia screening activities in family planning and STI/STD clinics across the country. Programs have also extended screening activities beyond those clinics to reach to high-risk young women in juvenile detention and other correctional facilities, adolescent health centers, community health centers, school-based programs, and Indian Health Service clinics.

The CDC awards money to each state based on equal proportions of female population ages 10-34 as calculated from the 1995 census and females ages 10-44 at 100 percent of the federal poverty level.

Significant funding principles for IPP are as follows:

- A minimum of 50 percent of resources must be allocated to Title X family planning programs unless there is a written agreement between family planning and sexually transmitted disease programs to fund other programs.
- IPP-supported screening sites should demonstrate a chlamydia positivity rate of 3 percent or above.
- Up to 10 percent of IPP project area funds can be spent for gonorrhea screening and treatment if positivity rates warrant.

Through directives provided each year by CDC in the continuing applications for STD/IPP funding, CDC requires that state public health programs target their IPP testing funds to the areas of the state with the highest rates of chlamydia and gonorrhea. MDH is required to determine these areas using local surveillance data.

National Chlamydia Coalition



The National Chlamydia Coalition was established in January 2008 by Partnership for Prevention, CDC, and eight founding organizations that make up the Steering Committee. The NCC is comprised of national non-profit organizations, health care professional associations, advocacy groups, health insurers, and local, state and federal government representatives. There are three committees that actively work to improve and protect the health of adolescents and young adults by increasing chlamydia screening, educating providers, providing public education, advocating for policy changes related to chlamydia screening and treatment services, and encouraging research. The organization is located in Washington, D.C. and the website is www.ncc.prevent.org.

In 2010 the NCC awarded mini-grants to regional, state and local to implement innovative strategies to increase chlamydia screening and follow-up care. Ten organizations were funded around the U.S. and MDH was awarded a mini-grant to hold the Summit on Chlamydia that was held in August 2010.

Minnesota Infertility Prevention Project (MIPP)

Since 1996, the MDH has participated in the Infertility Prevention Project. Several years ago, the IPP was expanded to also cover the cost of screening for and treating gonorrhea. The goal of the MIPP is to increase the number of adolescents and young adults screened in order to detect and treat chlamydia and gonorrhea, decrease transmission, and prevent many of those youth from experiencing serious and costly consequences.

The MIPP provides funding to specific community, public health and family planning clinics across the state to help defray a portion of their laboratory and medication expenses. The public health laboratory in Minnesota does not provide lab services related to the MIPP so funded clinics utilize the private, county and hospital-based laboratories with which they contract for other lab services. Since a portion of the dollars must be utilized by Title X family planning clinics, a portion of the funding has always been awarded to Title X recipients in Minnesota. Due to the limited funds available to Minnesota, all dollars must be applied to laboratory and treatment costs only. MIPP funds may not be used for staff salaries, travel, educational activities or materials.

Clients receiving free screening and treatment must be uninsured, sexually active females ages 15 through 25 and their sex partners. The CDC screening guidelines (see **Section 5**) also recommend screening for women age 26 and over if they have certain risk factors or have symptoms. However, in Minnesota, IPP funds only reimburse for screening done on women age 25 and under because they are not sufficient to reimburse clinics for tests performed on older women. In addition, clinics must maintain a 3 percent positivity rate for chlamydia or above in order to receive funds.



Clinics in Minnesota Participating in MIPP

A request for proposals process was conducted by the STD and HIV Section at MDH in April 2009. Thirty clinics operated by five entities were qualified to receive MIPP funds through 2013. Currently funded clinics are:

- Saint Paul-Ramsey County Public Health – Women’s Clinic (Title X) and Room 111, an STI/STD clinic; located at 555 Cedar St. in Saint Paul, MN.
- Hennepin County Department of Health and Human Services – Public health STI/STD clinic, formerly called the Red Door; located at 525 Portland Avenue South in Minneapolis, MN.
- Health Start, a program of West Side Community Health Services - Operates school-based clinics in 10 public high schools in Saint Paul, MN.
- Teen Age Medical Services, a component of Cedar Riverside People’s Center – An adolescent health clinic specializing in family planning and STI/STD diagnosis and treatment; located at 2425 Chicago Avenue South in Minneapolis, MN.
- Planned Parenthood of Minnesota, South Dakota and North Dakota (Title X) – 16 clinics located in Greater Minnesota; the only system of adolescent-friendly clinics located in rural areas and smaller communities in Minnesota that specializes in providing family planning services and STI/STD diagnosis and treatment to women of all ages.

Funding for MIPP

As stated earlier, the funds that currently support chlamydia screening and treatment activities in Minnesota are federal funds from the CDC. MIPP’s ability to fund screening efforts is directly affected by available funding. Funding appropriations decided each year by Congress determine the amount of money that the federal Infertility Prevention Project receives. This can fluctuate from year to year but funding levels have remained consistent in 2008-2011 at \$368,405 per year.

All chlamydia prevention and reduction activities in Minnesota are exclusively funded with federal dollars. The only funding that the MDH has received from the state of Minnesota related to STIs/STDs was to conduct a three-year study of the prevalence of several bacterial and viral STIs/STDs in 1997. Results related to chlamydia that were obtained from that study helped to inform MIPP efforts during and after the study.

Regional Infertility Prevention Project Activities

In each of the 10 federal Department of Health and Human Services (DHHS) regions, representatives of state STI/STD programs, state family planning and women's health programs, and the state public health laboratories meet several times a year as Regional Advisory Committees with a common goal of improving detection and treatment of persons with chlamydia and gonorrhea infections. Within each regional committee, participants work together to formulate a common approach to the prevention of chlamydia and gonorrhea infection and their complications. Data that evaluate program impact are collected and sent to CDC quarterly.

In Region V, the federal region in which Minnesota is located, staff members from IPP programs in Illinois, Indiana, Ohio, Michigan,

Key Components of Regional Infertility Prevention Programs

1. **Clinical** (screening, treatment, partner management)
2. **Training and Education** (of clinicians and laboratorians)
3. **Laboratory** (tests, bulk purchasing, performance, turn-around-time, quality assurance)
4. **Surveillance** (local, state, regional data collection, management, and analysis)

Wisconsin and Minnesota meet jointly for regional and national updates on chlamydia and to discuss areas of mutual interest. Semi-annual meetings in Region V are coordinated by Health Care Education and Training, a Title X training center located in Indianapolis, Indiana. Since 1996, representatives from the Minnesota IPP have attended regional meetings and brought back invaluable information that has greatly benefitted chlamydia efforts in Minnesota.



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Section 7: Common Issues with Wide-Reaching Implications

This section identifies six issues that impact all of the strategic arenas of the Minnesota Chlamydia Strategy. Ideas for how to address some of these issues are included in the tactics presented in **Section 1**. Additional ideas still need to be developed as various groups look how to implement and expand the Minnesota Chlamydia Strategy.

Chlamydia is a personal health issue and a public health issue that must be addressed by medical providers and health systems. However, chlamydia is more than simply a health issue so it must be addressed by a broad spectrum of interested parties.

Rationale

The opportunity for health begins in our families, neighborhoods, schools and jobs. The same factors that contribute to other socio-cultural issues, such as drug and alcohol use, teen pregnancy, family dysfunction, low self-esteem and depression, obesity, lack of sufficient and appropriate education, and sexual violence also contribute to why a sexually active young person takes the risk of contracting an STI/STD by having unprotected sex rather than making a healthier choice. In order to impact the chlamydia epidemic, community leaders and state and local government representatives need to confront the epidemic from a variety of perspectives. A multi-layered problem requires multi-faceted solutions.

There are extremely high numbers of cases of chlamydia so it is evident that the people who are contracting the disease are already sexually active and either unaware of or unable to implement the information they need to keep from getting the disease, and/or unable to access the care and services they need once they have had unprotected sex. We need to ask why this is occurring in a state that prides itself on innovation and providing a high standard of living for all residents. All Minnesota citizens, regardless of age, education, income or ethnic background should have opportunities to make choices that allow them to live healthy lives.

The MCP is committed to promoting awareness, engagement, and action on the many factors that can affect the health of all of us and to building partnerships to address the epidemic of chlamydia on every level. We encourage our partners, grantees and contractors, and other relevant stakeholders to join us on this journey to identify the best and most promising options, and to engage in sustained and coordinated actions that can begin to bring down the high rates of chlamydia in Minnesota.

Issues of Policy

At the State Level

Public policy has great impact on the types and extent of education and clinical services that are provided to adolescents and young adults. The Healthy States Initiative was formed to help state leaders access the information they need to make informed decisions. This Initiative brings together state legislators, CDC officials, state health department officials and public health experts to share information

and to identify innovative solutions to several health concerns, including chlamydia. In their 2007 Legislator Policy Brief, several areas where public health has educated the public and offered interventions are identified:

- Ensuring that children and at-risk adults are immunized against deadly diseases;
- Assisting victims of chronic conditions such as cancer, heart disease and asthma;
- Preventing disease and disability resulting from interactions between people and the environment;
- Researching how HIV/AIDS infections and other sexually transmitted diseases can be prevented;
- Promoting the health and well-being of people with disabilities; and
- Working with schools to prevent risky behavior among children, adolescents and young adults.

The Brief goes on to say, “State legislators, [along with city and county officials,] play a vital role in determining the structure and resources available to state and local agencies dedicated to protecting the public’s health.” The Brief suggests the following ways that state legislators can help to reduce the rates and prevent chlamydia:

- “Sponsor or support legislation requiring insurers to cover annual chlamydia screening.
- Serve on or support legislative task forces and focus groups that help to inform and motivate colleagues, and raise awareness and support for public advocacy for screening and treatment services.
- Promote funding for chlamydia screening and treatment for low-income and uninsured populations.
- Support or sponsor chlamydia prevention alliances among state and local departments of health and health care professionals.”

In the Legislator Policy Brief cited above, there are many examples of specific ways that state legislators can contribute to state and local efforts to identify and treat those people who are infected with chlamydia. Funding is part of the picture and there are additional ways to become involved. To view the Legislator Policy Brief, go to: <http://www.healthystates.csg.org/NR/rdonlyres/62DCD744-4CD2-406B-8540-08C690F2493B/0/chlamydia.pdf>. For more information on the Healthy States Initiatives, go to <http://www.healthystates.csg.org>.

There are several places in **Section 1** of the Strategy where suggestions are given for addressing funding and policies in specific ways on both state and national levels.

At the Local Government and Community Level

Effective chlamydia prevention requires changing community norms and attitudes toward sexuality and the structure and availability of health care services as well as changing the behaviors that place people at risk and encouraging the behaviors that reduce risk. Community organizations, local public health clinics, communities of faith, people concerned about social justice issues, youth, schools and school officials, and anyone else interested in impacting rates of chlamydia need to get involved. Input is needed and forming local coalitions of people who share a desire to make a difference can be very effective. The first step is to get acquainted with what the issues are and learn about things that need to be accomplished.

At the Clinic or Institution Level

Clinics and other medical institutions and facilities that provide STI/STD services can examine their internal policies and procedures to see if those policies make it easy for people to receive the STI/STD

related care for which they are eligible or whether they provide barriers. Identifying and treating chlamydia early is an effective and cost-saving approach to reducing rates because it stops the spread of infection and reduces the risk of serious complications. Although annual chlamydia screening is recommended by CDC for all sexually active women age 25 and under, in 2005 less than half of young women in commercial insurance programs were screened and only slightly more than half of young women who were in Medicaid programs. There is a great deal that needs to be done to adequately screen and treat all the people who are eligible and potentially at risk.

Issues of Funding

There are multiple ways in which greater funding is needed for federal programs, state programs in education, health and human services, and for local agencies. In addition, other entities, such as insurance and health plans, have an economic interest in reducing rates of chlamydia infections as a way to reduce health care costs. Involvement by these organizations is important as it relates to funding for screening, treatment, prevention and community education. Laboratories are also part of the picture, as the cost of testing continues to rise. Please refer to **Section 1** of the Strategy where there is additional information on funding needs and suggestions for possible actions.

Issues Related to Health Inequities

People living in communities of color, especially African Americans living in the Twin Cities, are disproportionately affected by chlamydia. All youth under age 25 living in Minnesota are disproportionately affected by chlamydia, regardless of geographic location. There is a great need to more effectively reach geographic areas and social networks where disease is especially concentrated. It is important that the structural, social, cultural and political factors that influence the physical, emotional and mental health of individuals be taken into account as we examine how to reach those who are most impacted and at risk. Messages and programs focused on communities of color must be culturally appropriate and administered in culturally competent ways by individuals who are from the affected communities or who are sensitive to these issues and have received training. It is important that communities that are affected are involved in all levels of planning, decision-making and implementation if programs are to be effective and successful. The people most affected will have the best answers.



Issues Related to Public Education

There is a general lack of awareness and education among Minnesotans about all aspects of chlamydia. Planning community education events and media campaigns designed to get people talking will be extremely important. It is likely to take many years to raise the public's awareness about chlamydia to the level of awareness people have of other social issues such as teen pregnancy, drug use, sexual violence and childhood abuse. Most of these topics also have a component related to sexuality; however, STIs/STDs have never had the level of attention that these issues have. As with several other issues that have sexual and gender components, the topic is complicated by issues of ageism, sexism,

racism and heterosexism. The moral, ethical and religious biases that are raised in discussions of topics related to sex also hinder constructive conversations and acceptable solutions.

Issues of Stigma and Shame

The MCP realizes that education alone is not the answer. American culture is saddled with decades of shame and secrecy related to sexuality in general. Chlamydia and other STIs/STDs add another layer of stigma that, along with the often unspoken attitude that STIs/STDs are punishment for bad behavior, keep people from admitting they might be at risk or in need of education and health care. A great deal of courage, humility and compassion will be needed in order to construct meaningful conversations that make a difference and move people into sustainable, effective actions that can better the health and lives of Minnesota youth.

Issues of Data and Research

While state and national organizations have a plethora of data on cases of disease, and we have multiple studies on certain aspects of STI/STD care and education, we are still in need of additional data and research at the national, state and community levels specifically related to chlamydia. Some examples include:

- 1) Cost analysis study of chlamydia in Minnesota;
- 2) More in-depth analysis of county-level numbers and trends; and
- 3) Concrete evidence that primary prevention education for non-sexually active individuals can impact rates of STIs/STDs.

Conclusion

In order to impact the chlamydia epidemic, community leaders and state and local government representatives need to confront the epidemic from a variety of perspectives. A multi-layered problem requires multi-faceted solutions and the MCP believes the issues listed above must be included in all discussions and plans.



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Section 8: The Minnesota Chlamydia Partnership

Current Structure

At the time this document is published, the Minnesota Chlamydia Partnership is composed of people representing the seven organizations who have been participating in the Steering Committee, all who attended the Summit on Chlamydia in August 2010, and anyone else that has requested to be added to our mailing list. The only requirements for membership are that individuals and groups must care about the health of adolescents and young adults in Minnesota and must support the vision, guiding principles and goals of the MCP.

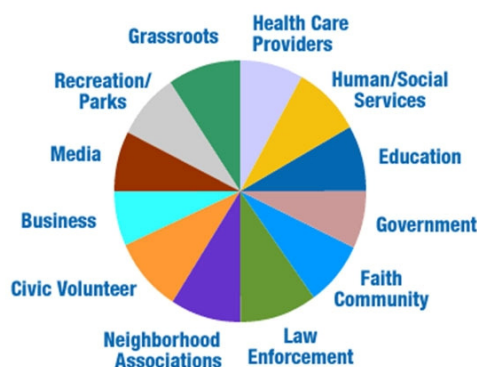
Coordination of the MCP

Although the initial meetings and activities of the MCP have been facilitated by the STD and HIV Section of MDH, the intention is for MDH to be one of many members in this coalition. MDH will continue to facilitate MCP activities in the immediate future. However, the MCP is seeking a more permanent coordinating body that is representative of a segment of the population or works with youth and/or health issues to manage the Partnership in upcoming years.

Involving all of the Community in the Minnesota Chlamydia Partnership

Representatives from a broad cross-section of the community are needed in order to address the epidemic in as many ways as possible. Anyone who cares about youth and health and is from any of the following groups in any community is invited to join the Minnesota Chlamydia Partnership.

- Schools and school officials: school nurses, health educators, school board members, administrators, health and family life teachers, Minnesota Department of Education
- Medical providers who conduct screening for chlamydia and gonorrhea in their clinical settings, including family planning, teen clinics, school-based clinics as well as private providers.
- Professional associations representing health care providers
- Community health workers
- Youth, ages 15-30 years of age (e.g., peer educators, youth advisory boards, etc.)
- Parents of teens
- Policy makers, especially those with interest in policies related to teens such as comprehensive sexuality education, minor consent
- Health plans, health insurers
- Laboratories that perform diagnostic testing for STIs/STDs



The Community Wheel

www.MarinInstitute.org

- Community based organizations that work with youth and issues affecting youth
- Local public health agencies
- Community and county boards, city councils
- Members of the faith community
- Health staff representing juvenile and adult correctional facilities
- Civic and community service organizations, especially those with youth programs
- Tribal governments
- Culturally specific programs serving people of color
- Organizations serving gay, lesbian, bisexual, transgender and questioning (GLBTQ) communities
- Divisions within state government who work on health issues, especially pertaining to youth
- Individuals living in Greater Minnesota
- Individuals living in the suburban areas outside of Minneapolis and St. Paul
- Individuals living in the urban, inner-city areas
- Grantees and contractors for MDH
- Others who wish to promote sexual health for everyone
- Media
- Business, especially those whose audience/customers are youth

If you would like to join the MCP, please notify Candy Hadsall
at 651-201- 4015 or candy.hadsall@state.mn.us.

Participation in this Partnership is open to everyone.

Next Steps for the Partnership

During 2011, meetings of the Steering Committee will be scheduled as needed. The majority of the efforts of the MCP will consist of members of the MCP Steering Committee meeting with community groups interested in exploring ways to implement actions suggested in the Strategy. Members of the larger MCP or of the Steering Committee will be available to attend meetings in the metro area and in Greater Minnesota as resources allow. The MCP hopes to help communities build local or regional coalitions where possible or to join existing coalitions that are working on related issues. A group could also use the Strategy as a springboard for additional ideas and projects; members of the MCP could provide guidance at the group's request.

Simultaneously, members of the MCP will be contacting possible funders and potential collaborators to discuss how more organizations can become involved in activities created or expanded as a result of the Strategy. We are seeking people in decision-making positions who have energy for improving the sexual health of youth and who will become champions of the Strategy and the need to take action to improve the sexual health of youth in Minnesota.

Future of the Minnesota Chlamydia Partnership

A goal of the MCP is to locate another entity that would be willing and has the internal capacity to take over facilitation of the group in upcoming years. In order for the Partnership and this Strategy to be successful, the people who are most impacted, directly and indirectly, must contribute to the creation of the Strategy and be invested in the solutions. Because the epidemic of chlamydia is a complex issue, created by a host of factors, the solutions must be multi-faceted and driven by the people most affected.



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Section 9: Minnesota Chlamydia Partnership Success Stories

MCP Success Stories

In the process of building the MCP, learning more about chlamydia, and becoming energized to address the epidemic, members of the Partnership were motivated to explore activities within their own agencies that could contribute to impacting the rates of chlamydia in the state of Minnesota. We consider these to be successes.

Here are a few examples of those successes:

1. In the words of a workgroup member: “Through our Access to Testing/Treatment Strategy Work Group, we met people we didn’t know. We learned a lot about innovative chlamydia testing and treatment practices. We brought this information back to our work settings and asked questions that we hadn’t been asking. For example, how these strategies can be applied to our own setting; how we can do a better job of training our own providers; how we can make sure chlamydia is tested for, not based on how a person looks, but what a person does.

“We met people who can come and speak to us about different issues related to STDs. It was great to have health plans at the table. We seldom get the chance to interact with them. As a result, we learned how much the health plans in Minnesota really care about testing and treating chlamydia.”
2. Erin Pratt with St. Paul-Ramsey County Public Health is looking to expand services for HIV and STD testing. Through her participation in the Access to Testing and Treatment Workgroup, she met Dana Hays, Director of Development at Face-to-Face Clinic. They are now jointly exploring the possibility of expanding testing at Face-to-Face Clinic.
3. As a result of participating in meetings of the Access to Testing and Treatment Workgroup, Lisa Dornick from Minneapolis School Based Clinics, spoke with her public health director, Gretchen Musicant, about the possibility of Minneapolis school clinics mentoring new school based clinics, as well as inviting legislators to view the clinics in order to advocate for funding.
4. Candy Hadsall and Kathy Chinn, both on the MCP Steering Committee and both MDH employees, were able to land a spot on the “It’s a Woman’s World” cable TV show on the Metro Cable Network that reaches the seven-county metro area. They were interviewed for 15 minutes and talked about women’s sexual health, particularly focusing on the chlamydia epidemic. It twice a day on March 14 and March 21, 2011.
5. Holly Dukowitz and Erin Francis, members of the workgroup looking into the role of health care providers, engaged the medical director and other providers in the OB/Gyn practice in which they work to examine their policies and protocols related to chlamydia screening and treatment. As a result, the clinic is negotiating with staff of MDH to bring education and training on chlamydia to their clinic so that they can increase the amount of screening done in their clinic.

6. Patricia Dumonceaux BSN, PHN, a Child and Teen Checkup (C&TC) Coordinator working for Morrison County Public Health, shared what she has been learning about the need to increase chlamydia screening with other C&TC coordinators in her region. As a result, a presentation was provided to their regional group and since then, they have been discussing ways to advocate for more chlamydia screening with the providers who are seeing teens for their checkups.



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Acknowledgements

The following are people who have contributed to the formation and activities of the Minnesota Chlamydia Partnership since its inception in January 2010. Many of them are members of the Minnesota Chlamydia Partnership Steering Committee. In addition to attending meetings of the Steering Committee, all of them also served as facilitators for the Strategy workgroups. Many of the Minnesota Department of Health staff that are listed participated in multiple meetings of the Steering Committee as well as many other internal meetings while others supported the activities of the Summit on Chlamydia and/or have advocated for the concept of a statewide coalition and Strategy to other internal and external parties. We are grateful to everyone for their untiring belief in and contributions to this work.

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MOAPPP (Brigid Riley)

Cincinnati STD and HIV Training Center (Barbara Boylan)

Gail Bolan, California Department of Health, STD Control

Strategy Workgroup Members

The following individuals participated in multiple meetings of the Strategy Workgroups between September 2010 and January 2011.

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Peter Carr
Candy Hadsall



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Glossary of Terms

Centers for Disease Control and Prevention (CDC): A branch of the federal Department of Health and Human Services.

Diagnostic testing: Testing those individuals who report having signs/symptoms of a STD or contact with someone who was found to be positive in order to determine if the person is infected.

Expedited Partner Therapy (EPT): The term describing a mechanism for medical providers to give patients diagnosed with a STD medications for them to give to their partners. The medication for the partner can be provided in the form of a prescription or the actual medication; the provider does not need to know the name of the partner for the prescription and the partner does not have to be seen by a provider before taking the medication. Legislation to allow this was new in Minnesota in 2009.

Goal: A statement that articulates the purpose or broader vision. They may or may not be attained by the end of the process. They are the results toward which efforts are directed; the rationale for the effort.

IPP – Infertility Prevention Project (IPP): A national program funded by Congress since 1996 to help medical providers, especially family planning clinics, cover the cost of providing screening for chlamydia and gonorrhea and treatment for sexually active females and their sexual partners who are positive and who do not have insurance or the financial means to pay for testing. The overall goal is to prevent long-term consequences that can result from untreated chlamydia and gonorrhea. In Minnesota, the IPP is called the Minnesota Infertility Prevention Project (MIPP).

Minnesota Chlamydia Partnership (MCP): A coalition originally composed of seven organizations and the Minnesota Department of Health that was formed in 2010 to raise awareness about the epidemic of chlamydia in Minnesota.

Nucleic acid amplification tests (NAATS): A method of testing performed by laboratories that uses amplification of the DNA present in a specimen to diagnose a disease. NAATS tests are considered the test methodology of choice on urine specimens from males and on swabs of the cervix and vagina in females and swabs of the urethra in males. Some clinics may also collect swabs of the mouth and throat and the anus.

Objective: Objectives are the building blocks to achieving goals; they are time-limited and measurable. Objectives describe the what, who, when, why and how of an issue and should outline the anticipated outcomes of a project.

Percent positive: The number of people tested out of the number of people who tested positive.

Prevalence of disease: The proportion of individuals in a particular population who have a disease at a given time.

Rates of disease: Number of reported cases per number of people in a certain geographic area in a specific period of time. (Example: 20 cases of chlamydia per every 100 people.)

Screening criteria: The factors that determine who should be offered screening tests for chlamydia and gonorrhea.

Sexually transmitted infection: The invasion of bodily tissues in the genital region by a microscopic organism. The organism multiplies and may produce subsequent tissue injury that can also progress to more obvious and serious disease. Sexually transmitted infections are passed from one person to another by direct sexual contact during intimate activities involving oral, anal or vaginal sex. In adults they are virtually never acquired by contact with inanimate objects such as toilet seats or towels. They can also be passed by mothers to their newborn babies during the birthing process.

Sexually transmitted disease: A pathological condition of a body part, organ, or bodily system that results from various causes, such as infection, genetic defect, or environmental stress, and is characterized by an identifiable group of signs or symptoms. Sexually transmitted diseases are diseases that affect reproductive organs or tissues in the genital area and they are spread primarily by direct sexual contact during oral, anal or vaginal sex. They can also be passed by mothers to their newborn babies during the birthing process.

STD screening: Offering testing for sexually transmitted diseases (STDs) to any patient coming into a clinic for any reason, without suspecting that the patient may be positive for any disease.

Strategic arena: A defined area or topic around which actions could be taken by an individual or groups of people interested in addressing chlamydia in Minnesota.

STD surveillance system: General term referring to the system for collecting data on the number of diagnosed cases of STDs reported to MDH. The system reports out the number of positive cases per number of people in the population over a specific period of time resulting in the rates of disease.

Tactics: Actions that will lead to the achievement of objectives.



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