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FAMILY PLANNING
NATIONAL TRAINING CENTER

CHLAMYDIA SCREENING CHANGE PACKAGE

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INTRODUCTION

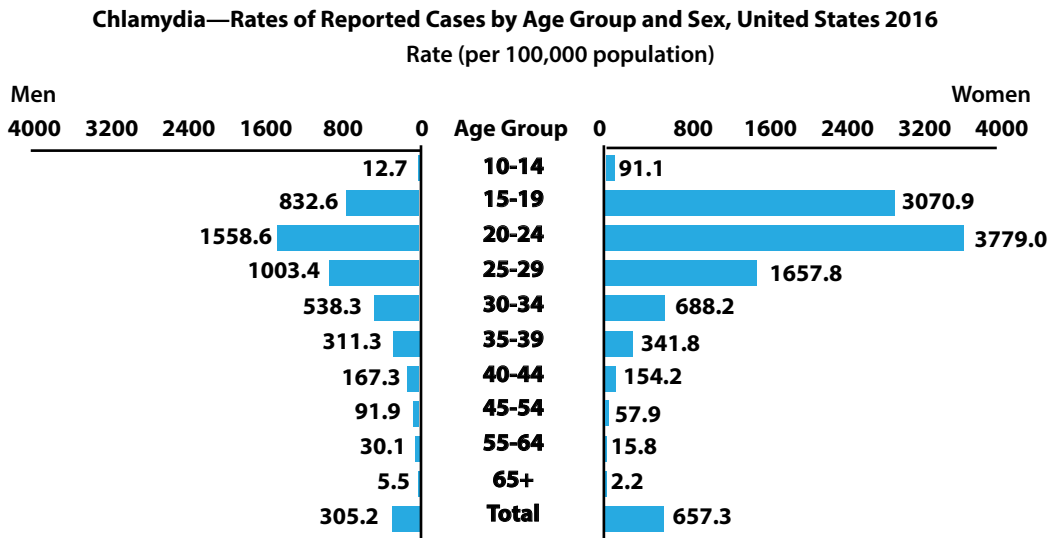
Chlamydia is the most commonly reported notifiable disease in the United States.¹ In 2016, there were over 1.6 million cases of chlamydia reported to the Centers for Disease Control and Prevention (CDC).² The highest chlamydia rates are among adolescent (ages 15-19) and young adult (ages 20-24) women.³

The highest rates are among women ages 15-19 and 20-24, with a rate of 3,070.9 and 3,779.0, respectively, compared to a rate of 657.3 cases per 100,000 among women of all age groups (Figure 1).¹

There are significant racial disparities in chlamydia rates, where the rate among Black women is 5.6 times greater than the rate among White women.¹

While usually asymptomatic, if left untreated, chlamydia infection in women can lead to pelvic inflammatory disease (PID), a major cause of infertility, ectopic pregnancy, and chronic pelvic pain.¹ Chlamydial infection also increases susceptibility to the transmission of human immunodeficiency virus (HIV).¹ Chlamydia is easily detected and, if identified, treatable with antibiotics.

FIGURE 1. Source: CDC Sexually Transmitted Disease (STD) Surveillance Report, 2016 (Figure 5)¹



SCREENING GUIDELINES

Because of the high burden and risks associated with chlamydia infection, and the asymptomatic nature of the infection, health care providers rely heavily on screening tests.⁴ CDC and the U.S. Preventive Services Task Force (USPSTF) have developed screening recommendations for chlamydia. According to the [CDC STD Treatment Guidelines](#):⁴

“Annual screening of all sexually active women aged <25 years is recommended, as is screening of older women at increased risk for infection (e.g., those who have a new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has a sexually transmitted infection). Although CT incidence might be higher in some women aged ≥25 years in some communities, overall the largest burden of infection is among women aged <25 years.”^{5,6}

The [CDC STD Treatment Guidelines](#) and [CDC STD Screening Recommendations](#) also include guidance for screening men.^{4,5}

*“Although evidence is insufficient to recommend routine screening for *C. trachomatis* in sexually active young men because of several factors (e.g., feasibility, efficacy, and cost-effectiveness), the screening of sexually active young men should be considered in clinical settings with a high prevalence of chlamydia (e.g., adolescent clinics, correctional facilities, and STD clinics) or in populations with high burden of infection (e.g., MSM).”⁴*

For men who have sex with men (MSM) the STD Screening Recommendations are to screen “at least annually for sexually active MSM at sites of contact (urethra, rectum) regardless of condom use, and every 3 to 6 months if at increased risk.”⁵

According to the USPSTF, “...current evidence is insufficient to assess the balance of benefits and harms of screening for chlamydia and gonorrhea in men.”⁷ The CDC STD Treatment Guidelines state that, “Among women, the primary focus of chlamydia screening efforts should be to detect chlamydia, prevent complications, and test and treat their partners, whereas targeted chlamydia screening in men should only be considered when resources permit, prevalence is high, and such screening does not hinder chlamydia screening efforts in women.”⁵

A National Committee for Quality Assurance (NCQA), National Quality Forum (NQF)-endorsed measure based on the [USPSTF clinical guidelines](#) is widely used to monitor the percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.⁷ Yet in 2015, half (49.8%) of sexually active female enrollees ages 16-24 in plans reporting Healthcare Effectiveness Data and Information Set (HEDIS) were screened for chlamydia.⁸ Because of these low screening rates, chlamydia screening is a public health priority. Increasing the percentage of sexually active women 24 years and younger enrolled in either Medicaid or commercial insurance who are screened for chlamydia is a HEDIS measure, and a Healthy People 2020 goal.^{3,9}

GOALS OF THE CHANGE PACKAGE

The goal of this change package is to support an increase in Title X grantees' chlamydia screening rates. Improvement can be tracked using the HEDIS chlamydia screening measure:

The percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.³

Although this HEDIS measure focuses on women 16-24 years of age, improvement activities should address all women and men at risk of chlamydia, as defined above.⁴

Based on a review of the literature, four best practice recommendations and suggested strategies for implementation of these practices have been identified:

» **BEST PRACTICE 1. Include chlamydia screening as a part of routine clinical preventive care for women 24 years and younger, women >24 who are at increased risk,ⁱ and men at increased risk.ⁱⁱ** Use clinic support systems to systematically screen sexually active clients at least once a year based on age and sex, or risk.⁴

» **BEST PRACTICE 2. Use normalizing and opt-out language to explain chlamydia screening to all women 24 years and younger, women >24 who are at increased risk, and men at increased risk.** Use sample scripts and staff role plays to help standardize the conversation.⁴

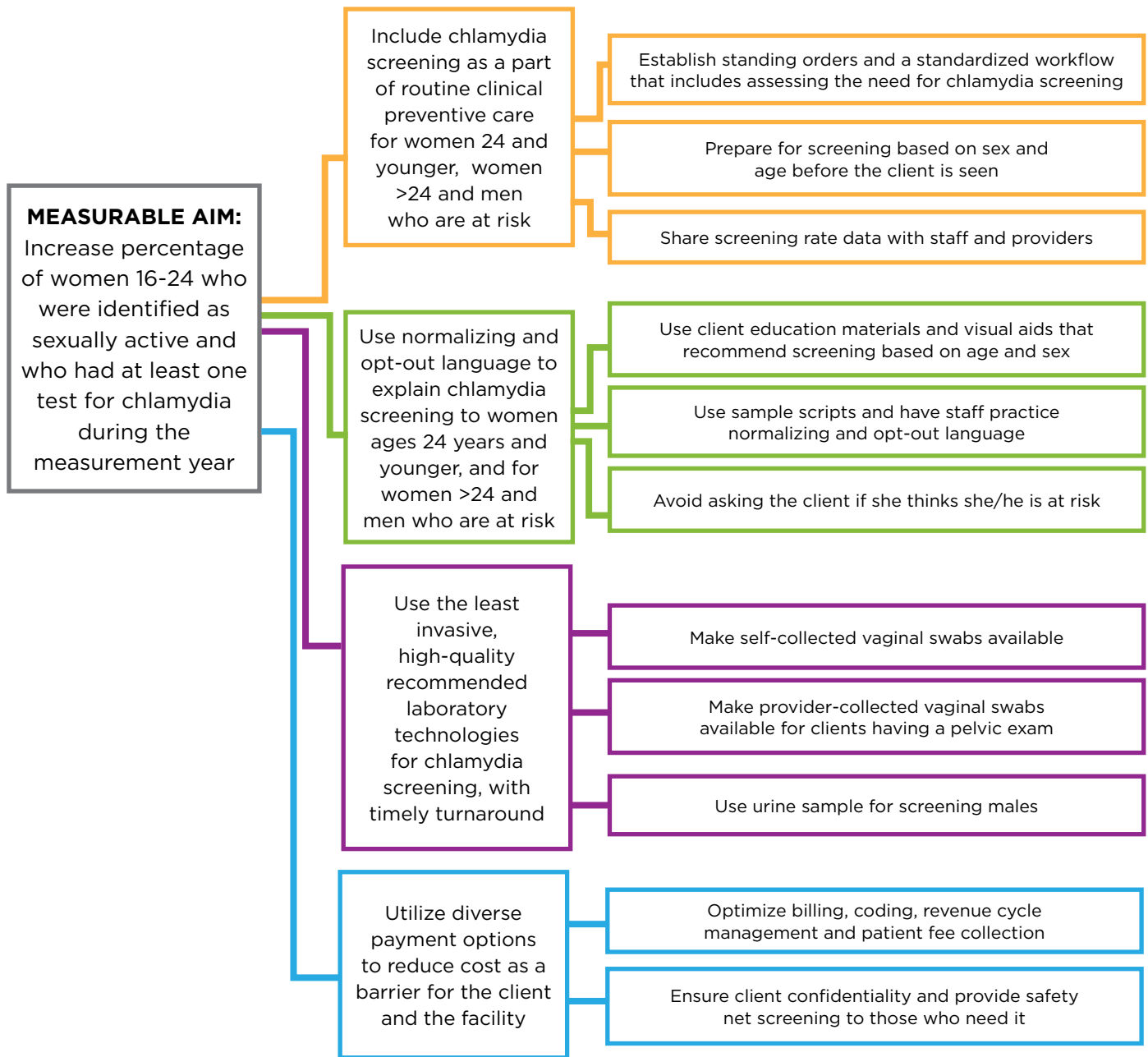
» **BEST PRACTICE 3. Use the least invasive, high quality, recommended laboratory technologies for chlamydia screening with timely turnaround.** Make all optimal urogenital specimen types available, including self-collected vaginal swabs for women.⁴

» **BEST PRACTICE 4. Utilize diverse payment options to reduce cost as a barrier for the client and the facility.** Inform clients about self-pay, sliding fee schedules, and insurance enrollment options.

i Women at increased risk for infection are defined by the CDC STD Treatment Guidelines as, for example, "those who have a new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has a sexually transmitted infection."

ii According to the STD Treatment Guidelines, "targeted chlamydia screening in men should only be considered when resources permit, prevalence is high, and such screening does not hinder chlamydia screening efforts in women. More frequent screening for some women (e.g., adolescents) or certain men (e.g., MSM) might be indicated."

FIGURE 2. Driver Diagram



HOW TO USE THIS CHANGE PACKAGE

This change package will support sites to develop a comprehensive strategy for increasing chlamydia screening among clients at greatest risk.

Specifically, this change package can help support your efforts to:

- » Increase awareness of best practice strategies associated with opt-out chlamydia screening among women 24 years and younger.
- » Increase awareness of best practice strategies associated with increasing chlamydia screening for women >24 who are at increased risk, and men at increased risk.⁵
- » Compare best practice recommendations and strategies with existing practices in your clinic.
- » Identify systems-level approaches to increasing chlamydia screening among targeted populations.
- » Select high-impact strategies to implement in your clinic to increase performance—including client-level, provider-level, and systems-level strategies.

A supplementary set of tools that can support implementation of these strategies can be found on [FPNTC.org](https://www.fpntc.org).

FPNTC Sexually Transmitted Disease Services Training Package:

For more information on chlamydia screening resources through the Family Planning National Training Center, see the training package on [Sexually Transmitted Disease Services](#).

Quality Improvement eLearning Modules:

For more information on quality improvement, see the training package on [Quality Improvement \(QI\)](#).

A five-part eLearning series builds knowledge related to conducting quality improvement in the family planning setting.

- » [Introduction to Quality Improvement for Family Planning](#)
- » [Quality Improvement Methodologies: Using the Model for Improvement](#)
- » [Data-driven Quality Improvement](#)
- » [Implementing Sustainable Quality Improvement](#)
- » [Building a Culture of Quality for Family Planning](#)

Family planning sites are encouraged to discuss implementation of these strategies and QI processes with each other.

BEST PRACTICES

BEST PRACTICE 1.

Include chlamydia screening as a part of routine clinical preventive care for women 24 years and younger, women >24 who are at increased risk,ⁱ and men at increased risk.ⁱⁱ Use clinic support systems to systematically screen sexually active clients at least once a year based on age and sex, or risk.⁴

RATIONALE

Chlamydia and gonorrhea screening should be incorporated as a routine part of preventive care for sexually active women 24 years of age and younger, for women >24 who are at increased risk, and men at increased risk. For sexually active women 24 and younger, before the client is seen, staff can prepare to screen for chlamydia and gonorrhea and integrate it as part of care in the same way that weight and blood pressure are a part of routine care. STD screening can be normalized by taking a sexual history and explaining the national screening recommendations for all sexually active women 24 years and younger annually.^{10,11} In addition to preventive health visits, clinic staff should include a consideration for chlamydia screening for women 24 years and younger routinely in all visits, including walk-in visits, such as those for pregnancy tests and emergency contraception counseling. If the client has not been screened in the past year based on the medical record, opt-out screening should be provided, as the client may not return for a preventive health visit. The evidence is especially strong for the importance of screening clients who present for pregnancy tests. In several studies, chlamydia positivity rates have been found to be higher among women seeking pregnancy tests than the clinic population as a whole.¹²⁻¹⁷ Note: clients always have the right to

refuse a service, if they choose to.

STRATEGIES

- » Have a written policy and protocol for screening all sexually active women 24 years and younger for chlamydia and gonorrhea as a routine part of preventive health care and for women >24 who are at increased risk, and men at increased risk.⁵
 - Staff should check the screening history and assess the need to screen at any visit and not just at preventive health visits, especially for adolescents.
- » Establish standing orders and a standardized workflow.
 - Implement site-level protocols to establish a standard workflow and utilize clinic support and reminder systems to support routine chlamydia screening.
 - Review the chlamydia screening history before the client arrives in clinic.
 - Work with office staff and/or the practice manager to implement clinic-level policies, protocols, and procedures. Outline who is responsible for specific tasks, when to do these tasks, and how.
 - Use templates or stickers to remind providers and clients about chlamydia screening.
 - Establish a chlamydia screening prompt in the electronic health record (EHR).
 - Consider including a “hard stop” in the EHR that includes asking staff to identify “reason for not screening” for all women 24 years of age and younger.
- » Utilize a team approach to increase chlamydia screening rates.

- Utilize trained non-clinician team members to identify screening based on a standard algorithm and provide client education that is appropriate to level of education.
- » Share screening data with staff and providers. Providers and clients are often focused on immediate concerns rather than on preventive health screenings. Many providers overestimate their screening rates. Sharing their data with them in comparison to a performance goal, or to their peers, may increase their awareness of opportunities to screen.
 - Share site- and provider-specific screening rates with staff.
 - Show the site- and provider-specific screening rates in comparison to national averages and to a target screening rate.
- » Utilize new service delivery approaches that increase efficiency and expand opportunities for screening.
 - Capitalize on client wait times by having them complete assessment forms and specimen collection.
 - Develop a protocol with standing orders for express visits for routine asymptomatic STD screening.
 - Use technology to facilitate risk assessment and clinic flow through apps, tablets, kiosks, and handouts that can be used while waiting in the clinic to see a provider or before and after a visit.
 - Consider introducing group presentations for patients on STD prevention methods, such as how to use condoms and the importance of routine screening.⁵

RESOURCES

- » [2015 STD Treatment Guidelines](#) (Source: CDC)
- » [National Network of STD Prevention Training Centers](#) (Source: CDC)
- » [Adolescent Health Care 101: The Basics](#) (Source: Adolescent Health Working Group)
- » [A Guide to Taking a Sexual History](#) (Source: CDC)
- » [Client-Administered Sexual History Questionnaire](#) (Source: California STD Prevention Training Center)
- » [Why Screen for Chlamydia? An Implementation Guide for Healthcare Providers](#) (Source: National Chlamydia Coalition)

SUCCESS STORY

When **Pasco County Department of Health**, a sub-recipient of the Florida State Department of Health, explored barriers to increasing chlamydia screening rates for female clients 24 years and younger, they realized that they were only screening during annual exam visits. Recognizing that fewer and fewer clients were coming to the clinic for annual exams, Pasco County Department of Health decided to introduce chlamydia screening as a part of routine clinical preventive care at all visits, including pregnancy test-only and nursing visits.

Key components of implementing this change were educating clinical staff about the high chlamydia rates in Pasco County, and sharing their success in increasing chlamydia screening rates by screening at all visits. Before expanding screening in June 2017, Pasco County's chlamydia screening rate for female clients 24 years and younger was 52%, which increased to an average of 78% in the months following the expansion.

BEST PRACTICE 2.

Use normalizing and opt-out language to explain chlamydia screening to all women 24 years and younger, women >24 who are at increased risk, and men at increased risk. Use sample scripts and staff role plays to help standardize the conversation.

RATIONALE

Lack of awareness of chlamydia screening guidelines and the social stigma associated with STDs may prevent clients, particularly adolescent and young women, from seeking chlamydia and gonorrhea screening services.¹⁸

Offering screening with normalizing language makes it a routine part of clinical services and is an effective way to build rapport with clients.¹⁰ Although data are limited for chlamydia screening, using an opt-out approach with women 24 years and younger has been demonstrated to increase rates of HIV testing, and is recommended in the 2006 CDC recommendations for HIV testing.¹⁹

Questions such as, “Do you want to be screened?” or, “Do you need to be screened?” are associated with high rates of decline as well as with the assumption that clients know when they need screening. Clients may have limited knowledge and understanding of the importance of, and recommendations for, chlamydia screening. The use of language stating that it is normal to screen (“we screen everyone in your age group”) is in line with CDC screening recommendations for chlamydia and reduces the perception of judgement, anticipation, and discomfort with talking about sex.^{5,10} End the discussion with, “Do you have any questions or concerns?” Finally, allow for clients to accept or refuse services, without judgement.

STRATEGIES

- » Encourage repeat annual preventive health visits for women 24 years and younger for the purposes of chlamydia screening.
- » Include all staff—including front desk, support staff, nurses, and providers—in training about chlamydia screening efforts.
 - Train all staff on normalizing language for all clients.
 - Train staff on opt-out language for women 24 years and younger, encouraging screening for at-risk clients regardless of reason for initial visit.¹¹
 - Ask open-ended questions, using the CDC’s list of considerations (the five Ps): partners, prevention of pregnancy, protection from STDs, practices, and past history of STDs.²⁰
 - Provide opportunities for clients to ask questions in order to fully understand what will happen during the visit and afterward.
 - Assure confidentiality. Explain any limits to confidentiality due to state/local laws or regulations at the beginning of the encounter.
- » Avoid asking questions such as:
 - “Do you want to be tested for chlamydia today?”
 - “Do you need to be tested for STDs today?”
 - “Are you sexually active?”
- » Share sample scripts and have staff practice role-playing with opt-out language such as:
 - “I recommend a test for chlamydia and gonorrhea to all my clients under 25.”

- “While you’re here today we should screen you, if that’s okay with you and unless you’ve done it recently.”
- “Chlamydia often has no symptoms. It’s a good idea for us to screen you today.”
- “We recommend routine screening much the same way immunizations are recommended.”
- “Testing for chlamydia is simple. Let’s test you today while you are here.”
- “We ask everyone if they have been screened at every visit.”
- “Did you know a chlamydia test is recommended for all women under 25 annually to prevent reproductive health consequences such as infertility and ectopic pregnancy?”
- “It sounds like today you are primarily here for a Depo injection, but, while you are here, since you are under 25, we should also screen you for chlamydia and gonorrhea, if that’s ok with you and unless you’ve had that done recently. Do you have any concerns or questions about that?”
- » All staff with client contact should receive training on:¹⁰
 - Preferred and acceptable specimen collection options and how to get a sufficient specimen
 - Current screening criteria and national screening recommendations and rationale for routine screening of clients 24 years of age and younger
 - The potential sequelae of untreated chlamydia, including the fact that chlamydia is the leading preventable cause of tubal factor infertility
 - Chlamydia prevalence and epidemiology; and
- » Train all staff with client contact on how to respond to positive results, including:
 - Importance of timely treatment, including partners;
 - Current recommendations for treatment, including abstaining from sex for 7 days after treatment;
 - Infectious disease reporting requirements;
 - Partner treatment options, including Bring Your Own Partner (BYOP), couples treatment, Expedited Partner Therapy (EPT); and
 - Recommendations for re-testing.
- » Educate clients on the importance of chlamydia screening annually, and how to reduce their risk for STDs.
 - Use messaging that is tested in the young female population. Messaging should normalize annual chlamydia screening and empower clients to get tested.
 - Make the messaging health-positive, provide simple action steps (e.g., get tested), and avoid alarming statistics.²¹
 - Combine messaging for chlamydia screening with other preventive health services such as HPV vaccines, drugs, etc.
 - Offer and promote condoms as a dual method protection for clients using other contraceptive methods to also protect against STDs.
 - Encourage clients who screen positive to ensure that their partner(s) are treated by allowing clients to bring partners to treatment appointments and offering EPT services if the partner cannot be treated directly.

- » Make client education materials widely available.
 - Include information on agency website.
 - Use an array of strategies including: signage in public places and exam rooms, materials to take home that fit in a pocket or purse, and brochures.²³
 - Consider using multimedia options such as videos in the waiting room.
 - Consider using available campaign messaging and materials from national campaigns such as Get Yourself Tested.²²

RESOURCES

- » [2015 STD Treatment Guidelines Print Version](#) (Source: CDC)
- » [Why Screen for Chlamydia? An Implementation Guide for Healthcare Providers](#) (Source: National Chlamydia Coalition)
- » [A Guide to Taking a Sexual History](#) (Source: CDC)
- » [Get Yourself Tested Campaign](#) (Source: CDC)

SUCCESS STORY

In 2017 **Butler County Health Department**, a sub-recipient of the Missouri Family Health Council, conducted an analysis designed to inform a quality improvement effort to increase chlamydia screening rates in women 24 years of age and younger. A key finding from the analysis was that staff were not using normalizing and opt-out language to introduce screening. Butler County Health Department responded by training clinic staff on how to introduce chlamydia screening using

normalizing and opt-out language, such as by telling patients screening is part of routine services—instead of asking if they “need” or “want” screening, as they had done in the past. They also provided opportunities for staff to practice using this language through role-playing during training sessions. In the five months following adoption of the new language, Butler County’s screening rates for women 24 and younger increased from an average of 26% to 62%.

BEST PRACTICE 3.

Use the least invasive, high-quality recommended laboratory technologies for chlamydia screening with timely turnaround.

Make all optimal urogenital specimen types available, including self-collected vaginal swabs for women.¹¹

RATIONALE

Historically, chlamydia and gonorrhea specimens were collected during pelvic exams as part of “annual exams” at the same time that pap testing was being conducted.²⁴ Recommendations for pelvic exams and pap testing have changed, and test technologies now allow for screening without a pelvic exam. This opens up new opportunities for increased efficiencies and the development of new models of care.²⁵ According to the 2015 STD Treatment Guidelines from the CDC, chlamydia and gonorrhea urogenital infections can be diagnosed in women by testing first-catch urine or collecting swab specimens from the endocervix or vagina.¹⁰

In line with the most up-to-date CDC recommendations, self- or clinician-collected vaginal swab is the recommended sample type. Provider collected vaginal swabs should be made available if a pelvic exam is being done, and self-collected vaginal swabs should be collected when it is not. A first catch urine specimen is acceptable, but might detect up to 10% fewer infections when compared with vaginal and endocervical swab samples.²⁶ Evidence suggests that self-collected and clinician-collected vaginal swab specimens are equivalent in sensitivity and specificity while clients find self-collection to be highly acceptable.¹⁰ Self-collected

vaginal swabs and urine specimens can be done without a pelvic exam and often align with clinic efficiency goals. Self-collected vaginal swabs can also be used regardless of a client’s urge to urinate, which can also be an advantage. Systems should be developed to make all of these options available, and all efforts should be made to use the least-invasive, high-quality test that is acceptable to, and convenient for, the client.

According to the [CDC STD Treatment Guidelines](#), “Diagnosis of *C. trachomatis* urethral infection in men can be made by testing a urethral swab or first-catch urine specimen.”⁴

STRATEGIES

- » Establish routine clinic flow processes and systems for routine screening.¹⁰
 - Systematize the collection of a self-collected specimen from clients for express visits.
 - Develop a protocol for a standardized clinic workflow to ensure access to screening with self-collected vaginal swabs as default care for clients 24 years of age and younger.
 - Provide instructions for how to properly collect a vaginal or urine sample.
 - Ensure access to options for screening for chlamydia using all accepted options for specimen collection—including urine, and self-collected vaginal swab.
 - Assess efficiency of clinic systems including specimen collection and identify opportunities for improving clinic flow and increasing efficiencies.

- » Procure lab services with timely turnaround. Labs should be able to process vaginal, urine and liquid-based cytology specimens with nucleic acid amplification test (NAATS); transport to lab within 1-2 days and provide timely turnaround within 2-3 days of specimen receipt.²⁷
- » Make all screening options available, including self-collected vaginal swabs. Provider-collected vaginal swabs can be used if a pelvic exam is being done, and self-collected vaginal swabs should be collected when it is not. A first-catch urine specimen is an acceptable alternative.¹⁰
- » Establish recall systems to retest clients three months after treatment in the case of a positive result.¹⁰

RESOURCES

- » [2015 STD Treatment Guidelines Print Version](#) (Source: CDC)
- » 2015 STD Treatment Guidelines App for [Android](#) and [Apple](#) Devices (Source: CDC)
- » [2015 STD Treatment Guidelines Pocket Guide](#) (Source: CDC)
- » [2015 STD Treatment Guidelines Wall Chart](#) (Source: CDC)
- » [2015 STD Treatment Guidelines Overview Webinar](#) (Source: CDC)
- » [Why Screen for Chlamydia? An Implementation Guide for Healthcare Providers](#) (Source: National Chlamydia Coalition)

SUCCESS STORY

In order to make testing as easy for women as possible, and to increase their screening rate, the **Nevada Health Centers** introduced vaginal swabs for chlamydia testing. After adjusting the workflow with this new testing technology, and addressing the implementation challenges associated with any new service, staff said it was working well. One frontline staff person said, “We used to have women in the waiting room just waiting until they had to pee. Now, with vaginal swabs, either the provider

does it during the exam, or they can do it themselves no matter what—and they’re much happier about that. No more waiting.” Having buy-in from the Chief Medical Officer, in conjunction with rolling out the new process at an all-staff meeting, helped Nevada Health Centers make this change.

BEST PRACTICE 4

Utilize diverse payment options to reduce cost as a barrier for the client and the facility. Inform clients about self-pay, sliding fee schedules, and insurance enrollment options.

RATIONALE

Chlamydia infections are often asymptomatic, but can result in harmful sequelae if left untreated.¹ Clients are often in the clinical setting seeking a different service, and may not see chlamydia screening as a high priority if they are there for a different “reason for visit.” This is especially true for clients expected to pay for services out of pocket. For insured clients, since the USPSTF has given chlamydia screening for young women under 25 a B grade, the Affordable Care Act (ACA) requires coverage of chlamydia screening without cost sharing, at least once a year.⁶ For clients who are uninsured or underinsured, the cost of chlamydia screening, however, can pose a barrier to accepting the service. In particular, self-pay clients may be likely to forego screening if it is going to add to the cost of the visit. Be familiar with your own state and local STD prevention initiatives that may help cover the cost of chlamydia testing at the local level. It is important to diversify payment options and to identify all available options to reduce the cost burden to the site and to clients.

STRATEGIES

- » Ensure organizational policy includes the following:²⁸
 - Clients must not be denied project services or be subjected to any variation in quality of services because of inability to pay
 - Charge all clients as appropriate. Projects should not have a general policy of no fees for minors, or a schedule of fees for minors that is different from other populations²⁸
 - Clients whose documented income is at or below 100% of the federal poverty level (FPL) must not be charged, although projects must bill all third parties authorized or legally obligated to pay for services
 - A schedule of discounts is required for individuals between 101% and 250% FPL
 - For families over 250% FPL, charges must be made in accordance with a fee schedule to recover the reasonable cost of providing services
 - Eligibility for discounts for unemancipated minors must be based on the income of the minor

- Where there is legal obligation or authorization for third party reimbursement, including public or private sources, all reasonable efforts must be made to obtain third-party payment without the application of any discounts
- Reasonable efforts to collect charges without jeopardizing client confidentiality must be made.
- » Ensure client confidentiality. Establish options for confidential billing for minors and vulnerable clients who do not wish to use their insurance.
- » Bill third parties when possible. When possible, obtain third-party reimbursement for clients with, or eligible for, third-party coverage such as private insurance, Medicaid, or family planning benefit programs.
 - Regularly review and, if necessary, re-negotiate contracts with insurance companies, including Medicaid managed care organizations, to ensure up-to-date reimbursement rates.
 - Work with state Medicaid to establish new payment strategies and ensure all related services are covered.
 - Collect copays at the time of visit.
- » Optimize billing and coding.
 - Conduct quality assurance procedures to ensure coding for chlamydia testing is accurate.
 - Conduct training, as needed, for providers, administrative, and billing staff to ensure full reimbursement for services rendered.
- » Provide insurance eligibility screening and application assistance for all clients identified as in need on site or by referral.²⁹
 - Provide access to a Certified Application Counselor (CAC), Navigator, or other Marketplace Assister on site or develop a formal linkage with federally qualified health centers or other organizations that can provide enrollment assistance.
 - Train financial staff to refer clients without insurance or in difficult financial situations to enrollment assistance services.
 - Educate all staff, including front desk/ receptionist, to answer basic questions about eligibility/enrollment and where clients can go to apply or renew; and to ensure confidentiality for those who require confidential billing.
 - Post “apply and renew” signage in public waiting spaces with information on how to connect with an enrollment assistance worker. Include information about financial assistance available in brochures, signage, and other promotional materials.
- » Develop strategies to pay for safety net screening services.
 - Identify and access all available sources of revenue including private and grant funding.
 - Inform clients about client assistance programs.

RESOURCES

- » [STD Billing and Reimbursement Toolkit](#)
(Source: STD TAC)
- » [Coding Guide for Nucleic Acid Amplification Testing to Diagnose Non-genital Infections with Gonorrhea and Chlamydia](#) (Source: American Medical Association)
- » [Getting the Coverage You Deserve Toolkit](#)
(Source: NWLC)
- » [Clinic Confidential Billing Algorithm](#)
(Source: STD TAC)
- » [Confidential and Covered Staff Workflow](#)
(Source: NFPRHA)
- » [Sample Financial Policy](#)
(Source: NFPRHA)
- » [Sample Client Policy and Form](#)
(Source: NFPRHA)
- » [Financial Dashboard](#)
(Source: FPNTC)
- » [Revenue Cycle Management Resources](#)
(Source: STD TAC)
- » [Common ICD 10 Codes for Family Planning](#)
(Source: FPNTC)

SUCCESS STORY

The **Family Planning Council of Iowa** partners with the Iowa Department of Public Health's STD Program to provide the state's Community-Based Screening Services (CBSS) program, which is supported with funding from CDC. The CBSS program provides testing and treatment for chlamydia and gonorrhea in select clinic sites, including family planning, across the state. The CBSS program has enabled the Family Planning Council of Iowa to increase its ability to offer screening. As a mechanism to pay for safety-net

screening, the collaboration reduces the costs of chlamydia screening for those at most risk and, in turn, expedites treatment for those that may not otherwise be identified and treated.

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