Discussion We found that even in an area which has achieved high screening coverage, few people were re-screened. However, positive cases are more likely to be retested than negatives. This detailed county level analysis will provide information to policy makers to develop a long-term, sustainable and effective screening strategy.

P5-S7.08 ASSESSMENT OF CHLAMYDIA TESTING COVERAGE USING HEDIS DATA: USA, 2009

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Background In the USA, chlamydia screening of all sexually active women aged ≤25 years is recommended, but screening rates are low. The Healthcare Effectiveness Data and Information Set (HEDIS) performance measure has tracked the time trend in screening since 2000. It has been found that among sexually active women aged 15–25 years, chlamydia testing rates increased from 25.3% to 41.6% during 2000–2007. While rates have increased, they remain suboptimal, and it is unknown whether testing rates differ significantly between 2007 and 2009 or by the type of health plan.
Methods The 2009 HEDIS chlamydia testing dataset was analysed to estimate the annual coverage among sexually active women aged 15–25 years who were enrolled in commercial health plans. Sexually active women were defined as those who had a claim or visit for pregnancy, contraception, cervical cancer screening, or STD diagnosis, screening, or treatment. A woman was counted as having a test if she had a claim or healthcare visit for any chlamydia test. Health plan types included in the HEDIS data are health maintenance organisations (HMOs), preferred provider organisation (PPO), point of service (POS), and any combination of HMO, PPO, and POS.
Results Of 2.4 million sexually active women, 54.5% were enrolled in PPOs, 28.7% in combined HMO/POSs, 13.8% in HMOs, 2.7% in combined HMO/POS/PPOs, and 0.3% in POSs. The overall annual chlamydia testing rate was 44.2% and significantly differed by plan type: 56.1% in HMOs, 45.7% in combined HMO/POSs, 44.6% in POSs, 41.2 in combined HMO/POS/PPOs, and 40.5% in PPOs.
Conclusions The annual chlamydia testing rate continued to increase between 2007 and 2009 (41.6% to 44.2%). However, the testing rate remains suboptimal, suggesting that additional interventions are needed to further increase testing rates. The highest testing rates were found in HMOs, healthcare settings that have interventions in place to promote provision of recommended healthcare services. The 2010 Affordable Care Act requires insurance plans cover preventive services such as chlamydia screening without patient cost sharing, and has the potential to increase chlamydia screening coverage throughout the US healthcare system. In light of these changes, it is important to continue to monitor chlamydia testing practices and to overcome barriers to testing.

P5-S7.09 IS ABANDONING URETHRAL SMEAR MICROSCOPY FOR THE DETECTION OF NON-GONOCOCCAL NON-CHLAMYDIAL URETHRITIS IN ASYMPTOMATIC MEN A COST EFFECTIVE STRATEGY?

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Background Asymptomatic non-gonococcal non-chlamydial urethritis (NCNGU) is common and can only be diagnosed by urethral smear microscopy. UK guidelines no longer recommend urethral smear microscopy in asymptomatic men, leaving men with this condition and their sexual partners untreated. The clinical and economic significance of this is unclear. We do not know if the costs of microscopy screening for asymptomatic NCNGU outweigh any future health benefits. We performed a model based economic evaluation to compare a screening strategy which includes microscopy to one which omits microscopy in asymptomatic men.
Methods The economic model was from the perspective of the UK health service and so only direct medical costs and outcomes are included. A hypothetical cohort of asymptomatic men who present at sexual health clinics, or at primary care is assumed to have *Chlamydia trachomatis*, *Neisseria gonorrhoeae* or NCNGU. In the economic model, untreated infections were taken into account for patients and their partners (pelvic inflammatory disease and tubal factor infertility in female partners). Probabilities and frequencies of these health events were informed by the outputs of a mathematical transmission model which used data from literature and national databases. A bottom-up costing estimated the cost for microscopy screening, while other cost inputs were sourced from published literature and online reference manuals for the economic evaluation. Appropriate sensitivity analyses were conducted to test the baseline results.
Results Currently, there are no robust quality-adjusted-life-year (QALY) data to value STI outcomes. Consequently, results will be presented as cost per major outcome avoided and cost per infection avoided, where major outcome averted refers to PID, infertility and tubal factor infertility. Incremental cost-effective ratios will be interpreted based on accepted precedents.
Conclusions The UK's current financial restraint has increased the importance of allocating resources based on need and value-for-money. This in turn, requires the UK health service to eliminate ineffective and inefficient services to create additional source of funding. Results from this study will indicate whether microscopy testing for asymptomatic men is good use of public money and whether funding for the service should be maintained.

P5-S7.10 CHLAMYDIA SCREENING COVERAGE AMONG AMERICAN INDIAN AND ALASKA NATIVE WOMEN IN THE USA

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Background Racial and ethnic minorities are often disproportionately affected by health disparities. In 2009, American Indian and Alaska Natives (AI/AN) had the 2nd highest rates of chlamydia in the USA. In an effort to eliminate health inequities and reduce the burden of disease, the US Centers for Disease Control and Prevention (CDC) recommends annual chlamydia screening for all sexually active women <25 while reducing screening among older less at-risk individuals. We sought to assess and describe geographic regional differences in how recommendations have been adopted across Indian Country to identify what opportunities exist for improving care within the Indian Health Service (IHS) National STD Program's Stop Chlamydia Project, a screening program that partners with IHS/Tribal/Urban Indian health centers (I/T/U) to enhance and expand chlamydia screening among AI/AN.
Methods We calculated chlamydia screening coverage rates and associated per cent positivity for women <25 and >26 years of age screened through sites participating in the Stop Chlamydia Project by geographic region. Screening coverage was calculated using the 2009 Indian Health Services facility-level user population estimates as denominator values.
Results Screening coverage among AI/AN women tested in Stop CT Project sites varied across geographic regions. Among women <25, rates ranged from 50.8% (Alaska) to 6.8% (California). Chlamydia

positivity among this population also demonstrated variance across geographic regions ranging from 13.2% (Aberdeen) to 4.6% (California). Among >26-year-old women, similar levels of screening were seen ranging from 34.4% (Alaska) and 5.7% (Bemidji); however, significantly less positivity was identified (1.4%–5.6%) (Abstract P5-S7.10 table 1).

Abstract P5-S7.10 Table 1 Chlamydia screening coverage among AI/AN women (≤25 & ≥26) by geographic regions, Stop Chlamydia Project—2009

Geographic Regions	# of Tests	≤25	% Positive	≥26	% Positive
Aberdeen (IA, NE, NS, SD)	8590	31.70%	13.20%	19.00%	3.80%
Alaska (AK)	12 185	50.80%	8.60%	34.40%	2.50%
Bemidji (MI, MN, WI)	190	10.90%	5.00%	5.70%	5.60%
Billings (MT, WY)	2630	28.70%	9.20%	18.70%	1.40%
California (CA)	173	6.80%	4.60%	6.10%	1.90%
Oklahoma (KS, OK)	2211	14.70%	11.60%	10.90%	2.80%
Portland (ID, OR, WA)	2063	28.80%	9.20%	23.80%	2.40%
Southwest (AZ, CO, NM, NV, TX, UT)	15 506	29.30%	9.40%	27.70%	4.00%
Nashville (AL, AR, CT, DE, FL, GA, IL, IN, KY, LA, MA, MD, ME, MO, MS, NC, NH, NJ, NY, OH, PA, RI, SC, TN, VA, VT, WV)	No participating sites				
Overall Total	43 548	31.50%	10.00%	23.80%	3.30%

Conclusions This is the first time screening coverage for American Indian/Alaska Native women has been evaluated by geographic regions. These data can help inform program improvement activities to maximise screening outcomes by expanding testing among women <25 years old and limiting routine screening efforts in older women (>26 years old) in order to better utilise testing resources to expand coverage among those at greatest risk for chlamydia (<25 years old).

P5-S7.11 CHLAMYDIA AND GONORRHOEA POSITIVITY AMONG FEMALES AGED 15–25 YEARS TESTED IN COMMUNITY HEALTH CENTERS IN 12 COUNTIES IN CY2009, REGION II INFERTILITY PREVENTION PROJECT, USA

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Background The US Centers for Disease Control and Prevention (CDC) recommends annual chlamydia screening for sexually active females aged <26 years. Community health centers (CHCs) have been a focal point for Health Care Reform in the US and have traditionally served as safety-net providers, however little is known about CT screening practices in CHCs or CT prevalence among CHC clients. The Region II Infertility Prevention Project (IPP) supports chlamydia and gonorrhoea (CT/GC) prevalence monitoring in participating facilities throughout New Jersey, New York, Puerto Rico and the US Virgin Islands, including a small number of CHCs.

Methods We reviewed Region II IPP CT/GC prevalence monitoring data for females aged 15–25 years tested in CY2009 attending CHCs for non-prenatal visits by age, test result, and laboratory test type, and compared with data for females attending family planning (FP) clinics for non-prenatal visits in the same counties. A total of 3103 CT and 2890 GC test records were associated with 18 CHCs in 12 counties in New Jersey, New York, and the US Virgin Islands; 35 FP clinics in the same counties reported 32 905 CT and 19 882 GC tests.

Results CT positivity among females aged 15–19 and 20–25 years in CHCs was 11.4% (n=640) and 5.7% (n=2463), respectively, compared with 8.5% (n=10 946) and 4.6% (n=21 959) in FP clinics in the same counties. GC positivity in CHCs was 1.3% (n=594) and 0.2% (n=2296) among females aged 15–19 and 20–25 years, respectively, compared with 1.0% (n=6548) and 0.3% (n=13 334) in FP clinics (Abstract P5-S7.11 table 1). Over 99% of tests in CHCs were performed using highly sensitive nucleic acid amplification tests (NAATs), vs 55% of tests performed in FP.

Abstract P5-S7.11 Table 1 Chlamydia and gonorrhoea testing and positivity among females aged 15-25 years attending community health centers and family planning clinics for non-prenatal visits, CY2009, Region II Infertility Prevention Project, USA

Test type	Age Group (Years)	Community health centers		Family planning clinics	
		# Tests	% Pos	# Tests	% Pos
Chlamydia	15–19	640	11.4%	10 946	8.5%
	20–25	2463	5.7%	21 959	4.6%
	Total	3103	6.9%	32 905	5.9%
Gonorrhoea	15–19	594	1.3%	6548	1.0%
	20–25	2296	0.2%	13 334	0.3%
	Total	2890	0.4%	19 882	0.6%

Conclusion The burden of chlamydia and gonorrhoea among females aged 15–25 years attending CHCs is comparable to that observed in FP clinics, and highest among teens. As state and local health departments face mounting budget deficits and impending cuts to public health infrastructure—including cuts to the delivery of direct clinical services, CHCs may play an increasingly integral role in providing screening to the most at risk populations. CHCs are required to report to HRSA (the federal agency that funds the CHC program) on their performance using the measures defined in the Uniform Data System (UDS); however, the UDS does not currently include a measure for the proportion of clients screened for CT/GC. State and local health departments should consider opportunities to partner with CHCs in high morbidity areas to ensure and expand access to CT/GC screening and treatment for at risk populations, and leverage existing infrastructure to incorporate CHCs into ongoing prevalence monitoring efforts.

P5-S7.12 STD TESTING IN EMERGENCY DEPARTMENT: A NOVEL METHOD TO PROVIDE TEST RESULTS

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Background Realising the potential of broad based STD testing depends on treatment of those with positive results. Because emergency department (ED) physicians expressed reluctance to test for STD's because they had no mechanism for giving test results, we devised a system to provide results to patients tested for STD's at the county's public hospital by calling Bell Flower, the health department's STD program, to determine whether patients tested for STD's in the ED would call for their results.

Methods An electronically generated individually modified referral note with instructions for calling Bell Flower for STD test results was given to all patients tested for STD's including gonorrhoea (GC), Chlamydia (CT) or syphilis, in the Wishard Hospital Emergency Department. The Bell Flower results clerk was given access to the hospital's electronic medical record system containing laboratory results. The clerk's access to a specific patient's results was recorded electronically by the system. Patient records accessed by