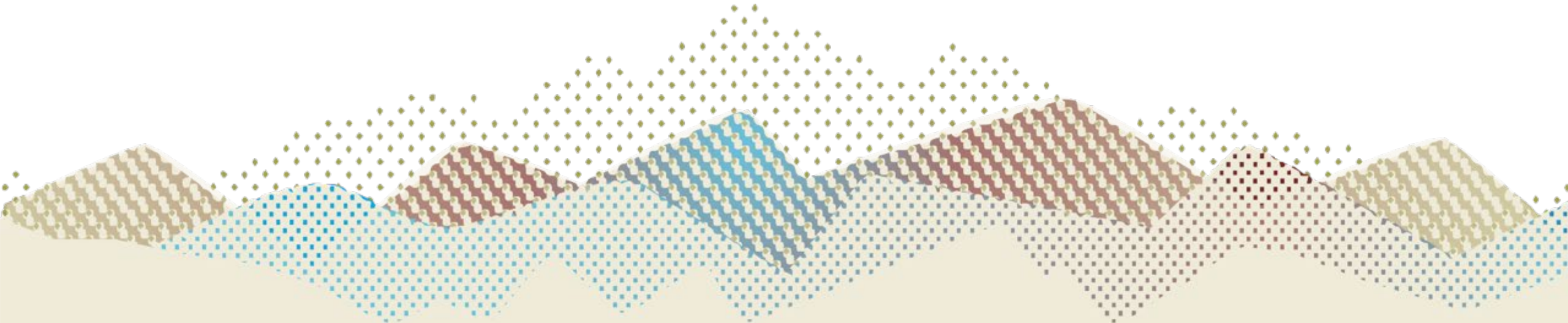


# Improving Measure Outcomes: Sexual and Reproductive Health

Colleen Townsend, MD, Regional Medical Director

Emily Wellander, MPH, LVN, Improvement Advisor

Dr. Lynette Leighton, Medical Director of The SexEd Justice Project



# Learning Objectives

- Identify best and promising practices including access to care, successful clinical workflows, member and staff education, outreach, addressing social context which influence treatment decisions, referrals to local community resources, disproportionate prevalence, and technical tips to improve sexual and reproductive health.
- Identify barriers for sexual and reproductive health and discuss best practices for implementing effective care practices.
- Describe the importance of discussing sexual and reproductive health with adolescents and young adults, including the prevalence and impact of chlamydia.

# Learning Objectives – *continued*

- Evaluate the prevalence and risk factors for chlamydia and associated health inequities prevalent in their diagnosis and treatment.
- Define the clinical background, specifications, and 2026 performance threshold definitions of the Provider Quality Incentive Program, including chlamydia screening.
- Apply measure specification requirements to maximize adherence and performance for chlamydia screening for persons assigned female at birth.

# Talking with Young People About Sexual Health

Dr. Lynette Leighton  
Medical Director of The SexEd Justice Project  
Associate Chief Medical Officer of Napa and Solano



# Agenda: Talking with Young People About Sex

Improving Chlamydia Screening in Primary Care (and all sexual and reproductive health!)

- Why screening matters
- How to start the conversation
- Systems changes that increase screening





# Why This Matters

Young people have the **highest rates** of chlamydia.  
Most infections occur in **ages 15–24**  
Many infections are **asymptomatic**

Untreated infection can lead to:

- Pelvic inflammatory disease
- Infertility
- Chronic pelvic pain

Primary care providers are the key entry point for screening.

It's also an opportunity to check in about safety and contraception.



# Screening Recommendations

U. S. Preventative Task Force:

Screen for chlamydia and gonorrhea:

Sexually active individuals assigned female at birth

Age  $\leq 24$ : routine screening

Age  $\geq 25$ : screen if increased risk

Testing is recommended even when patients have no symptoms.



# Screening Recommendations

U. S. Preventative Task Force:

Screen for chlamydia and gonorrhea:

Men who have sex with men

Men with high-risk behavior, multiple partners, new partners

# Partnership PCP QIP Chlamydia Screening Measure Rationale

The measure specification for PCP QIP is broader than the USPSTF screening recommendations to ensure screening of the highest risk individuals and those for whom risk is not identified or disclosed

# Why Talking About Sex Matters

Screening starts with asking about sexual activity.

Barriers that providers report:

- Discomfort discussing sex
- Limited time
- Concern about confidentiality
- Assuming patients will bring it up
- Parents in the room

Most young patients expect their provider to ask first.



# A Simple Way to Start

Room all patients alone from 12 to 18 years old.  
Explain confidentiality!

Normalize the conversation.

Normalize:

“I ask all my patients your age a few questions about relationships and sexual health so I can make sure we’re offering the right care.”

Then ask:

“Have you had any sexual contact?”

“What genders are your partners?”

For younger patients:

“Do you know if you like boys or girls or both?”

“Do you have a crush on anyone?”



Routine framing **reduces stigma and increases honesty.**

# Offer Screening Simply

Example language:

“Many infections don’t cause symptoms, so we recommend routine testing for people your age.”

“This is a simple urine test we offer to all sexually active patients.”

Routine screening makes testing easier for patients.





# Missed Opportunity: Sophia





# Sophia



Sophia is 19 years old and visits clinic several times in one year.

**Visit 1: Urgent care**

Sore throat visit  
No sexual history taken

**Visit 2: Telemedicine PCP visit**

Birth control refill  
No STI screening offered

**Visit 3: Urgent Care**

UTI symptoms  
Urinalysis done  
No STI testing

**Visit 4: PCP visit**

Annual physical  
Screening not discussed

6 months later: Sophia came to the clinic asking for a pregnancy test. Her pregnancy test was positive and she chose to continue the pregnancy. During routine pregnancy screening, her Chlamydia test was also positive.



Where were the missed opportunities?

Where could screening have happened?

# Where were the missed opportunities?

Where could screening have happened?

Urgent care visit

Contraception visit

UTI visit

Annual visit

Key point:

Young patients often have **multiple** healthcare encounters before screening occurs.

Making screening routine, can give a patient the opportunity to discuss other concerns, including contraception.

Confidentiality:

Mia



# Mia



Mia, age 14

Mia came to clinic with her father for a routine visit.

During this visit she received health care maintenance including vaccines and a sports physical. Her father remained present throughout the visit.

# Mia



Melissa, age 14

During this visit, Mia wanted to ask the provider about her pelvic discomfort, as she had recently become sexually active. However, she didn't say anything because she was worried that her father would find out.

# Mia



Melissa, age 14

Two weeks later, Melissa presented to the **Emergency Department** with:

- Severe pelvic pain
- Fever
- Pelvic inflammatory disease (PID)

She required:

- Antibiotics
- Emergency department care
- Follow-up for potential reproductive health complications

Earlier screening and treatment could have prevented this complication.

Where were the missed opportunities?

Where could screening have happened?



# Where were the missed opportunities?

Mia was not given confidential time with the provider.

Best practice:

- Room all patients age 12–18 alone for part of the visit
- Explain confidentiality
- Ask routine sexual health questions
- Offer screening when appropriate

Confidential care allows adolescents to disclose sensitive information that **they may not share in front of parents.**

# California Law Supports Confidential Care

In California, minors age 12 and older may consent to confidential care for:

- STI testing and treatment
- HIV testing and prevention
- Pregnancy testing and pregnancy-related care
- Sexual assault services

Under California Family Code §6925 and related Health & Safety Codes, providers generally cannot disclose this care to parents without the minor's permission unless safety concerns exist.

Confidential conversation with the adolescent is essential.



# Creating Systems:

A team approach to  
Chlamydia Screening



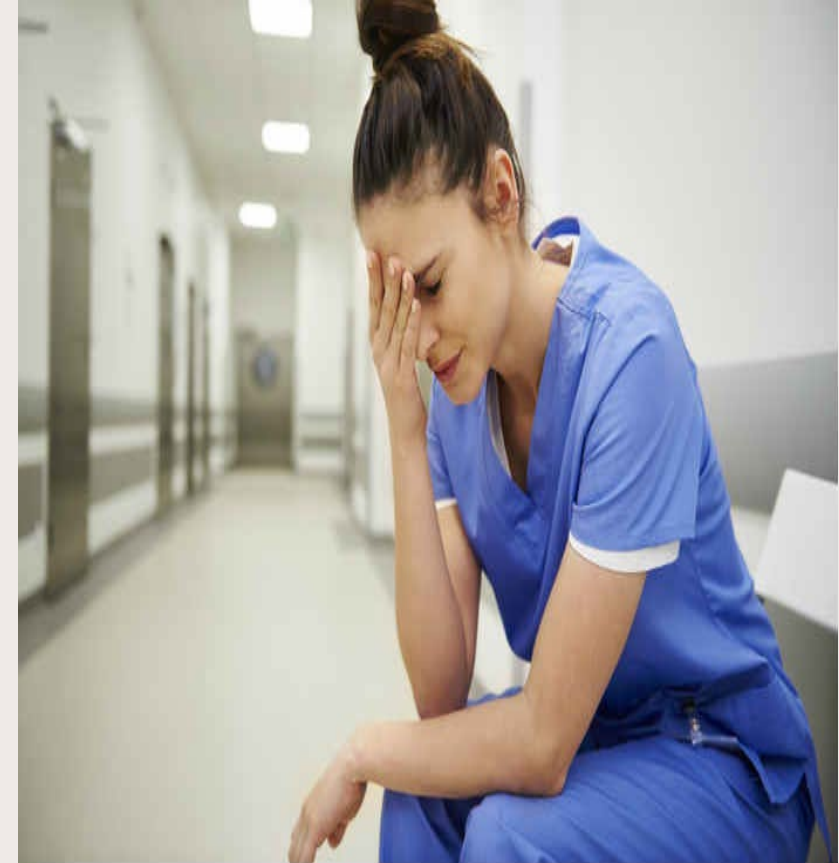
# Why Systems Matter

Improving screening cannot rely on provider memory alone.

Common system barriers:

- Screening not embedded in workflow
- Lack of reminders
- Time constraints
- Unclear team roles

Systems make the right action easier.



# Ideal Clinic Workflow: use your team!



## Team-Based Approach

Huddle before clinic: Identify patients 15–24yo girls and women who have not been screened in the past month

Request the front office collect urine for these patients

# Ideal Clinic Workflow: make it routine



Make it routine to collect urine for all girls and women between the ages of 15 and 25 years.

-front office collection

-Medical assistant collection

while rooming

# Ideal Clinic Workflow: Room patients alone for all visits



Rooming young people alone and without parents in the room:

Room 12-18 yo patients alone (and older)

Medical assistant provides **urine cup or self-swab**

.

# Ideal Clinic Workflow: Talk to your patients about sex



Rooming young people alone then take the opportunity to talk to them about sex and other sensitive issues.

Young people are waiting for YOU to bring this up!

.

# Ideal Clinic Workflow: Make Testing Easy

Reducing barriers increases completion.

Strategies:

- Urine-based testing

- Self-collected vaginal swabs

- No pelvic exam required**

- Offer screening during **any visit**

Convenience greatly improves screening uptake.





# Key Takeaways



Young people have the **highest chlamydia rates**

Annual screening recommended for **sexually active patients  $\leq 24$  assigned female at birth**

Many infections have **no symptoms**

Providers must **initiate the conversation and provide confidential visits**

- **Systems changes help prevent missed opportunities**

# Three Things to Start Tomorrow



- Normalize sexual health questions with all young patients
- Offer routine screening rather than waiting for symptoms
- Build clinic workflows so screening doesn't depend on memory

# Discussion

- What barriers exist in your clinic?
- What workflow changes could improve screening?
- How can we reduce missed opportunities?

# Thank you

Dr. Lynette Leighton  
Medical Director of The SexEd Justice Project

[Lynette.Leighton@communicareole.org](mailto:Lynette.Leighton@communicareole.org)





# Overview of QIP Specifications

## Chlamydia Screening

# MY2026 Primary Care Provider Quality Incentive Program (PCP QIP) Measure Specifications – Chlamydia Screening

- **Measure Description**

- Percentage of patients ages 16 – 20 for whom screening is indicated and who had at least one test for chlamydia during the measurement year (MY).

- **Denominator**

- Number of continuously enrolled assigned members assigned female at birth 16 – 24 years of age as of December 31 of the MY.

- **Numerator**

- Number of members from the eligible population in the denominator with at least one test for chlamydia during the MY.

- **Exclusions**

- Member receiving palliative care or who have had an encounter with palliative care any time during the MY.

## MY2026 PCP QIP NEW!

### **Pediatric:** Chlamydia Screening

(16 - 20 yo) *Partial Points:*

75<sup>th</sup> (65.47%), *Full Points:* 90<sup>th</sup> (70.67%)

### **Family Practice:** Chlamydia Screening

(16 - 24 yo) *Partial Points:*

n/a, *Full Points:* 50<sup>th</sup> (56.30%)

### **Internal Medicine:** Chlamydia

Screening (21 - 24 yo) *Partial Points:*

n/a, *Full Points:* 50<sup>th</sup> (56.30%)

# MY2026 Primary Care Provider Quality Incentive Program (PCP QIP) Measure Specifications – Chlamydia Screening



- **Measure Rationale and Source**

- The PCP QIP Chlamydia Screening measure focuses on increasing rates for chlamydia screening for individuals who are assigned female at birth and under the age of 24 years, reflecting the USPSTF recommendations.
- We support universal screening of all individuals assigned females at birth in the age range where chlamydia infection rates are highest
- Screening all individuals in this age group ensures screening for the highest risk individuals and prevents missing individuals whose sexual activity may not be known by the PCP practice.

# MY2026 Primary Care Provider Quality Incentive Program (PCP QIP) Measure Specifications – Chlamydia Screening



- **Measure Rationale and Source – *continued***

- Currently, systems are unable to effectively identify individuals who are sexually active, placing individuals at risk for complications due to undetected infection. Screening all individuals in this age range captures those seeking care who, based on age, are at highest risk for infections and complications of chlamydia. Furthermore, the HEDIS measure denominator identifies sexual activity based on administrative data such as a pregnancy test outside of the PCP practice (urgent care or emergency room), or a prescription /treatment with contraception regardless of the condition for which they are prescribed. This measure does focus specifically on females assigned at birth as the USPSTF concludes there is insufficient evidence to determine the balance of benefits and harms of screening males for chlamydia and therefore, do not make a recommendation for or against screening this population.



# Putting Quality Into Practice

## Chlamydia Screening

# Comparisons of Chlamydia Screening

## Opt-Out Screening

- Universal screening involves routinely testing individuals for sexually transmitted infections, regardless of reported sexual activity or perceived risk factors.
- Patients can refuse / opt-out.

## Risk-Based Screening

- Testing is offered only to those who are identified as having specific risk factors, as listed below:
  - Females 25 years of age and younger who report sexual activity
  - STI history
  - Pregnancy
  - High-risk sexual activity

# Chlamydia Screening Options

## Pros for Opt-Out / Universal Screening

- Higher screening rates
- Reduces stigma and misconceptions (testing is routine)
- Does not depend on risk disclosure
- Detects asymptomatic infections which facilitates linkage to treatment and reduces risk of transmission
- Cost effective in high prevalence population

## Cons for Opt-Out / Universal Screening

- May test some lower-risk individuals
- Requires system-level workflow integration

# Chlamydia Screening Options

## Pros for Risk Based Screening

- Targets higher-risk populations
- May reduce unnecessary testing

## Cons for Risk Based Screening

- Relies on accurate sexual history disclosure
- Patients may underreport risk
- Providers may not consistently assess risk
- Misses asymptomatic cases without obvious risk factors leaving chlamydia infections undiagnosed and untreated
- Can lead to long-term health complications
- Leads to missed opportunities

# Measure Best Practices

## MEASURE BEST PRACTICES

The Measure Best Practices documents are resources for the Primary Care Provider Quality Improvement Program (PCP QIP) measure set, which aligns closely with the Managed Care Accountability Set (MCAS) measures for which Partnership HealthPlan of California is held accountable by the Department of Health Care Services (DHCS). Each Measure Best Practice document is updated annually and includes Partnership tools and resources, guidelines to facilitate optimal member care, opportunities for patient education, outreach, and equity, data and coding resources, and helpful links to improve measure performance.

Breast Cancer Screening

Cervical Cancer Screening

Child & Adolescent Well Care

Childhood Immunizations Status

Chlamydia Screening



Colorectal Cancer Screening

Controlling Blood Pressure

Comprehensive Diabetes Care: HbA1c - Good Control

Comprehensive Diabetes Care: Retinal Eye Exam

Dental Fluoride Varnish

Immunizations for Adolescents

Lead Screening for Children

Well Child Visits 0-30 Months

Performance Improvement



## 2026 Best Practices Chlamydia Screening

### **Partnership Tools, Programs, and Promising Practices:**

- Attend or view Partnership's [Improving Measure Outcomes training](#) on *Sexual and Reproductive Health*.
- Partnership members can access transportation for non-emergency medical services for assistance in traveling to and from appointments. Members can access services by calling [Partnership Transportation Services](#) at **(866) 828-2303**, Monday – Friday, 7 a.m. – 7 p.m.

### **Patient Care:**

- Develop workflows to support USPSTF recommendations to annually screen all sexually active patients assigned female at birth between ages 16-24, and those aged 25 and older if at an increased risk for infection.

# Measure Best Practices – Before the Visit

- Develop workflows aligned with current screening guidelines.
- Educate team on screening guidelines and California minor consent and confidentiality laws.
- Build standardized templates in the EMR/EHR system to guide providers and staff through the visit to ensure all components are met and documented.
  - Include standardized sexual history into history and physical.
- Define team roles and create standardized scripts to explain the opt-out approach to patients and their caregivers.

# Measure Best Practices – Before the Visit (*continued*)

- Prepare caregivers and patients for separate time with adolescents (12+ years) to allow open and honest conversations.
- Use all visits as an opportunity to screen.
  - Well child / teen visits, acute visits, sports physicals, and back to school events.
- Establish a pre-visit workflow for clinical support staff.
  - Pre-visit planning, chart flags, huddles, prepped collection kits.

# Measure Best Practices – During the Visit

- Normalize the screening as routine preventive care
- Address any patient or caregiver questions early
- Educate patients and caregivers on confidentiality
  - STI screening is considered by Medi-Cal as a sensitive service; therefore, parental / legal guardian consent is not required for patients who are 12 years and older
- Collect urine sample at intake before the patient is roomed if possible
- Encourage patients to complete chlamydia screening during current appointment

# Measure Best Practices – During the Visit (*continued*)

- Ensure part of the visit is conducted privately with adolescents (12+ years)
  - Use standardized scripts for taking sexual history and reviewing the recommendations for screening
- Educate patients on sexually transmitted infections (STIs) including signs, symptoms, treatment, prevention, and resources
- Discuss how results are shared using confidential and preferred communication methods



# QIP Tools and Resources

# PCP Quality Improvement Program

## PCP QUALITY INCENTIVE PROGRAM

The Primary Care Provider Quality Incentive Program (PCP QIP), designed in collaboration with Partnership HealthPlan of California providers, offers substantial financial incentives, data resources, and technical assistance to primary care providers who serve our members so that significant improvements can be made in the following areas:

- Preventive Screening
- Pediatric Access
- Hospital Utilization
- Primary Care Utilization
- Chronic Disease Management
- Patient Experience

### Contact Us

Email: [QIP@partnershiphp.org](mailto:QIP@partnershiphp.org) (please allow two business days for a response)

Fax: (707) 863-4316

### PCP QIP Overview



To help orient our providers to the PCP QIP year, we have provided measurement set documents, a code list, and other useful tools and resources.

[Learn More about the 2026 PCP QIP](#)

[Equity Adjustment - PCP QIP Payment Methodology](#)

### Webinars

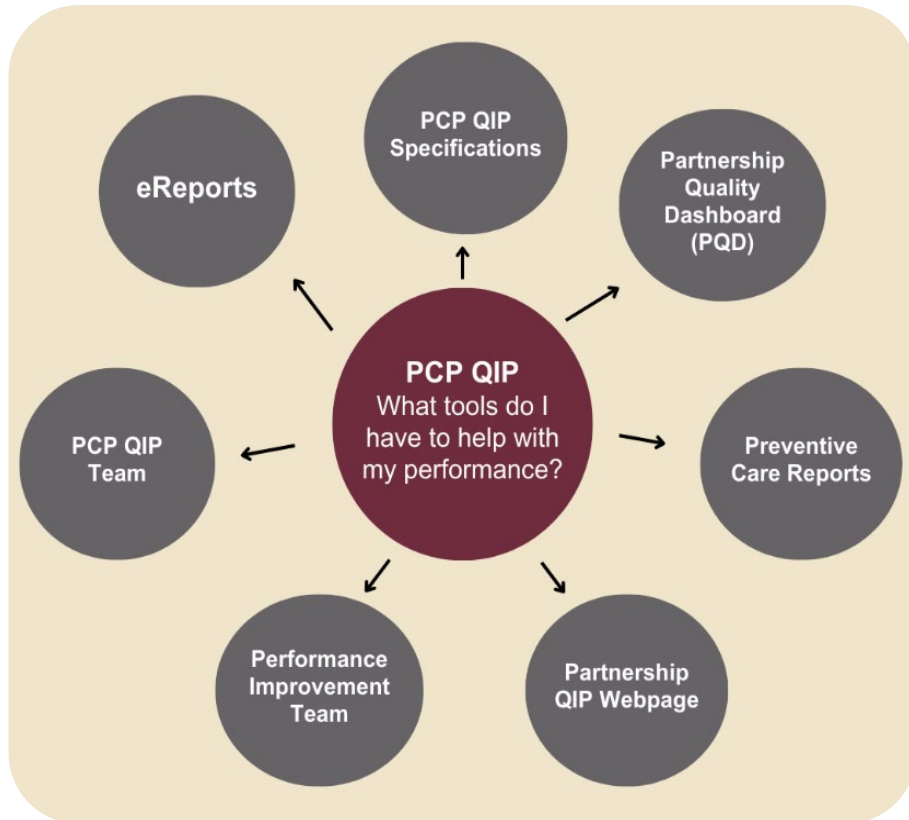


[PCP QIP Webinars](#)

[Upcoming Webinars and Trainings](#)

[On Demand Courses](#)

# Quality Incentive Program (QIP) Tools and Resources



- [2026 PCP Measure Specification Manual](#)
- [PQD User Guide](#)
- [PCP QIP Webpage](#)
- [eReports](#)

**QIP – eReports**

**Diagnosis Code xWalk Report**

[Back to report main page](#)

Select a Measure:	Chlamydia Screening 2026
Select a Code Type:	-- Select All --
<input type="button" value="Display"/> <input type="button" value="Clear"/>	



# Upcoming Trainings

# Improving Measure Outcomes Webinar Series



The Improving Measure Outcomes learning series is designed to help quality improvement teams turn knowledge into action. These sessions focus on Partnership's Primary Care and Perinatal Provider Quality Incentive Program (QIP) measures, offering practical strategies to close care gaps, advance health equity, and improve clinical outcomes.

## **Final Webinar in the 2026 Schedule**

*All webinars are held from noon to 1 p.m.*

April 22, 2026 – Improving Perinatal Outcomes

*\*Continuing education credits available.*

For details and registration, visit [Improvement Academy's event page](#).

Questions? Email [improvementacademy@partnershiphp.org](mailto:improvementacademy@partnershiphp.org)

# ABCs of Quality Improvement

An in-person training designed to introduce participants to key Quality Improvement (QI) methodologies, with a specific focus on the Model for Improvement – a widely used framework for driving measurable change in health care settings (*CME/CEs available*).

**Thursday, May 14, 2026**  
**8 a.m. – 4 p.m.**  
**Auburn**

[REGISTER HERE](#)



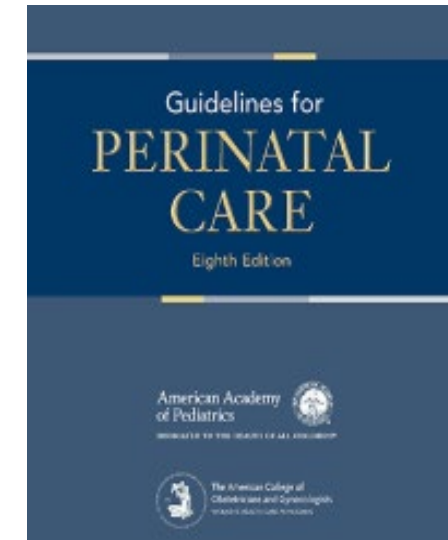
## **Course topics include:**

- *Basic Principles of Quality Improvement*
- *Introduction to the Model for Improvement*
- *Creating an Aim Statement*
- *Using Data to Measure and Drive Improvement*
- *Developing Change Ideas*
- *Testing Changes with the Plan-Do-Study-Act Cycle*

**Target Audience:** Clinicians, practice managers, quality improvement team members, and staff who are responsible for participating and leading quality improvement efforts within their organization.

# Reference Materials

- [Guidelines for Perinatal Care – 8th Edition](#) by the American College Obstetricians & Gynecologists (ACOG) and the American Academy of Pediatrics (AAP), September 2017
- California Department of Public Health CPSP Program  
<https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx>
- American Diabetes Association  
[Management of Diabetes in Pregnancy: Standards of Care in Diabetes – 2024](#) (January 2024)



# Additional Resources

- To reach the PCP QIP Team, email [QIP@partnershiphp.org](mailto:QIP@partnershiphp.org).
  - eReports access
  - Measure specification questions
- Interested in coaching resources for improving measure performance? Email the Performance Improvement Team at [pit@partnershiphp.org](mailto:pit@partnershiphp.org).
  - Coaching, measure best practices, sounding board, project planning guidance, facilitation.
- Partnership Quality Dashboard (PQD) [User Guide](#)
- [PCP QIP Webinars](#): 2026 Kick-Off Webinar recordings are now available for PCP QIP and eReports.

# Contact Us

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