Clinical Benchmarking Survey, Part II

Women’s Health Preventive Screening: Chlamydia Screening-CDC Guidelines

Background

The U.S. Centers for Disease Control (CDC) recommends chlamydia screening annually for all sexually active females under age 25. Chlamydia is known to be asymptomatic in most cases and can be a significant preventable cause of pelvic inflammatory disease (PID) that can lead to tubal occlusion and subsequent female infertility.

Process/Instructions

Each health center should review clinical visits from fall 2014 through spring 2015 (August 2014-March 2015), identifying visits by female students or for female-to-male transgender students who have an intact cervix. Charts should NOT be limited to patients seen in women’s health clinical areas only. They should be randomly selected across all clinical areas. The review may include the initial visit, up to one year prior, and subsequent visits. The same charts used for compliance with the American College of Obstetricians and Gynecologists (ACOG) guidelines for cervical cancer screening may be used when appropriate (patient meets criteria for both studies).

25 selected charts should meet the following inclusion criteria:

- patients seen at any time this academic year
- sexually active
- an intact cervix
- under age 25
This chart review assesses compliance with the CDC guidelines for chlamydia screening. The following information will be collected:

- Age of patient
- History of sexual activity
- Documentation of chlamydia screening within 12 months

Adherence to the chlamydia screening guidelines will be based on whether screening:

1. was indicated, but was not offered and not done by health services
2. was indicated and offered, but not done
3. was indicated and screening was done
## Chlamydia Screening Worksheet

<table>
<thead>
<tr>
<th>Chart #</th>
<th>Age</th>
<th>Sexually Active?</th>
<th>Chlamydia screening past 12 months?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Offered at SHS, declined</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>Yes</td>
<td>No</td>
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<td>3</td>
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<td>26</td>
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</table>
Clinical Benchmarking Survey, Part II

Women’s Health Preventive Screening:
Compliance with ACOG Guidelines on Cervical Cancer Screening

Background

Cervical cancer rates have fallen more than 50% in the past 30 years in the U.S. due to the widespread use of the Papanicolaou (Pap) test. The majority of deaths from cervical cancer in the U.S. are among women who are screened infrequently or not at all.

In November 2012, the American College of Obstetricians and Gynecologists (ACOG) updated their guidelines on cervical cancer screening. The revised recommendations are:

- **Initiate baseline cervical cancer screening at age 21, regardless of age of onset of sexual activity.**
- **Women from ages 21 to 29 should be screened every 3 years instead of annually, using either the standard Pap or liquid-based cytology.**
- **Women age 30 and older may be screened once every three years with either the standard Pap or liquid-based cytology alone or every 5 years with negative co-testing (Pap and high risk HPV screening both negative).**
- **Women with certain risk factors may need more frequent screening, including those who have HIV, are immunosuppressed, were exposed to diethylstilbestrol (DES) in utero, and have been treated for cervical intraepithelial neoplasia (CIN) 2, CIN 3, or cervical cancer.**
- **Routine cervical cytology testing should be discontinued in women (regardless of age) who have had a total hysterectomy (removal of the cervix along with the uterus) for noncancerous reasons, as long as they have no history of CIN 2, CIN 3, adenocarcinoma in situ, or cancer in the previous 20 years.**
- **Stop cervical cancer screening at age 65 among women with adequate negative prior screening results. Women with a history of CIN2, CIN 3, or adenocarcinoma should continue routine age-based screening for at least 20 years.**
- **Women who have been vaccinated against human papillomavirus (HPV) should follow the same screening guidelines as unvaccinated women.**
Moving the baseline cervical screening to age 21 is a conservative approach to avoid unnecessary treatment of adolescents, which can have economic, emotional, and future childbearing implications. Although the rate of HPV infection is high among sexually active adolescents, invasive cervical cancer is very rare in women under age 21, and the immune system usually clears the HPV infection within one to two years among most adolescent women.

**Process/Instructions**

Because the majority of the patients utilizing college health services are under age 30, this benchmark study will focus on the Pap test screening of patients with a cervix under age 30.

Each health center should review clinical visits from fall through spring (August 2014- March 2015), identifying visits by female students or for female-to-male transgender students who have an intact cervix. Charts should be selected randomly, across all clinical areas and visit types. Please do NOT limit selection to those patients seen in women’s health clinical areas only. The review will include the identified visit, up to three years prior, and subsequent visits.

25 selected charts should meet the following inclusion criteria:
- patients seen at any time this academic year
- an intact cervix
- under age 30
- average risk for cervical cancer (no known HIV, not immunocompromised, nor a history of CIN, ASCUS, or LSIL, or exposure to DES)

This chart review assesses compliance with the ACOG Cervical Cancer Screening Guidelines. The following information will be collected:
- Age of patient
- Pap history over the past 3 years

Adherence to the ACOG guidelines for cervical cancer screening will be assessed as follows:
1. Pap not indicated/Pap not offered/pap not done
2. Pap not indicated/Pap done
3. Pap indicated/Pap offered/Pap done
4. Pap indicated/Pap offered/Pap not done
5. Pap indicated/Pap not offered/Pap not done
<table>
<thead>
<tr>
<th>Chart #</th>
<th>Age (in years)</th>
<th>Pap performed in past 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No pap in past 12 months</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pap offered by SHS, declined</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pap offered, plans outside</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes, done at SHS</td>
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<tr>
<td></td>
<td></td>
<td>Yes, outside provider (reported)</td>
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<tr>
<td></td>
<td></td>
<td>Yes, outside provider (documentation)</td>
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<tr>
<td></td>
<td></td>
<td>Don’t know</td>
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<tr>
<td></td>
<td></td>
<td>No Pap Hx documented</td>
</tr>
</tbody>
</table>

1  | 2  | 3  | 4  | 5  | 6  | 7  | 8  | 9  | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 |
<table>
<thead>
<tr>
<th>No prior pap</th>
<th>Don't know</th>
<th>&lt; 12 months</th>
<th>12-24 months</th>
<th>24-36 months</th>
<th>&gt; 36 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>at SHS</td>
<td>outside provider (report)</td>
<td>outside provider (doc)</td>
<td>at SHS</td>
<td>outside provider (report)</td>
<td>outside provider (doc)</td>
</tr>
</tbody>
</table>
Clinical Benchmarking Survey, Part II

Management of Major Depression

Background

Major depression is a common and potentially serious health condition affecting college-age individuals. Recent studies suggest that the twelve-month prevalence of major depression among college students is 7%\(^1\). In 2009, USPSTF recommended screening for depression in adults and adolescents when appropriate supports are available.

Guidelines are available for both adults and adolescents\(^3\),\(^4\), with recommendations for monitoring treatment response using a standardized instrument. An appropriate initial assessment includes consideration of DSM criteria (or equivalent clinical criteria) as well as using a standardized instrument to assess baseline symptoms. Timely initiation of treatment and regular follow-up to assess response to treatment are key components to quality care. When treatment for depression is initiated, careful follow-up is required to ensure a remission is obtained. Use of the same depression tool used at initial diagnosis to monitor treatment response is recommended. No consensus exists about which instrument to use (i.e., PHQ-9 vs. Beck depression inventory); rather, the value of standardizing the severity of depressive symptoms is what is sought.

Process/Instructions

Each health center should identify 25 charts of patients receiving a new diagnosis of depression within the 3 to 15 months prior to the review. Chart identification recommendations include using diagnosis codes of major depressive disorder (ICD9: 296.20-296.39 or ICD10: F32s & F33s), depression NOS (ICD9: 311 or ICD10: F39), or dysthymic disorder (ICD9: 300.4 or ICD10 F34.1). Patients with bipolar disorders, psychoses, predominant eating disorders, or substance use disorders with active use are excluded. Co-occurring anxiety need not exclude that patient/chart from inclusion.

The chart review should identify the date/visit when the initial diagnosis or recurrence occurred, and all visits for the 3 months following that visit should be reviewed and used to complete the survey and answer the following quality measures.
1. The initial depression assessment—this should include:
   • Documentation of DSM IV or V criteria or clinical equivalent (i.e., SIG E CAPS) to make the diagnosis of a depressive disorder
   • Use of a standardized instrument to measure depressive symptoms (i.e., PHQ9 or BDI)
   • Documentation of past mental health, including depression and any prior treatment
   • Documentation of current suicidal ideation
   • Documentation of mental status

2. Follow-up visits occur at 4 weeks (range 2-6) and 8 weeks (range 6-10), include application of the same standardized instrument used initially, and documentation of response to treatment.

3. If inadequate response to treatment at the 4 and the 8 week follow-up, documentation of an increase in treatment (i.e., increasing medication dose or increasing frequency of psychotherapy appointments) or the addition of another treatment strategy (i.e., adding medication to psychotherapy or referral to a higher level of services).

If your health center does not screen for depression, does not diagnose depressive disorders, and does not participate in the depression management of students, then please check the noted box and skip this section of the clinical benchmarking survey.

If your health center screens, diagnoses, or participates in the depression care management of your student population, then please complete this clinical benchmarking survey. If the institution’s counseling center or psychiatry services assumes complete care of student’s depressive disorders, then the health center staff member should complete this survey using the counseling center’s documentation if shared chart/counseling notes are accessible to student health or by asking counseling center colleagues’ assistance in completing survey.

References

Management of Major Depression Worksheet

<table>
<thead>
<tr>
<th>Pt #</th>
<th>Initial assessment</th>
<th>4 wk follow-up (2-6 wk)</th>
<th>8 wk follow-up (6-10 wk)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Q1a y/n</td>
<td>Q1b y/n</td>
<td>Q1c y/n</td>
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<td>Q1d y/n</td>
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<td>Q1e y/n</td>
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<tr>
<td></td>
<td>Q2a y/n</td>
<td>Q2b y/n</td>
<td>Q2c w/n/p/c*</td>
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<td>Q2d d/s/i/uk**</td>
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<td></td>
<td>Q3a y/n</td>
<td>Q3b y/n</td>
<td>Q3c w/n/p/c*</td>
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<td></td>
<td></td>
<td></td>
<td>Q3d d/s/i/uk**</td>
</tr>
</tbody>
</table>

* w/n/p/c corresponds to w=worsening, n=no change, p=partial response, and c=complete remission
** d/s/i/uk corresponds to d=treatments decreased, s=treatments continued, same as before, i=treatments increased, uk=unknown
Patient # 1 (and repeat for 2-25)

1. The initial depression assessment includes:
   a. Documentation of DSM IV or V criteria or clinical equivalent (ie SIG E CAPS) to make the diagnosis of a depressive disorder
      ☐ Yes
      ☐ No
   
b. Use of a standardized instrument to measure depressive symptoms is documented (ie PHQ9, Beck, Zung, CES-D, or another standardized quantifiable measurement tool)
      ☐ Yes (which one:_______________________________)
      ☐ No

c. Past mental health, including depression and any prior treatment is documented in the visit note:
      ☐ Yes
      ☐ No

d. Presence or absence of current suicidal ideation is documented:
      ☐ Yes
      ☐ No

e. The student’s mental status is documented:
      ☐ Yes
      ☐ No

2. For the “four week follow-up”
   a. Is there a documented visit between 2 and 6 weeks following that initial visit in which depression is addressed?
      ☐ Yes
      ☐ No (skip to Q3)
   
b. Was the same standardized depression instrument administered during a visit between 2 and 6 weeks following the initial visit?
      ☐ Yes
      ☐ No (skip to Q 2d)
   
c. The score of this standardized instrument indicates*
      ☐ Worsening depressive symptoms, including active suicidal ideation
      ☐ No response (no change)

*w/n/p/c corresponds to w=worsening, n=no change, p=partial response, and c=complete remission
** d/s/i/uk corresponds to d=treatments decreased, s=treatments continued, same as before, i=treatments increased, uk=unknown
d. Was the depression treatment plan changed?**
   o Yes, treatments were decreased
   o No, treatment plan continued as initiated at last visit
   o Yes, treatment plan increased (ie referral to higher level of care, increased medication dose or changed medications, added an additional treatment)
   o Unknown (not documented, or no follow-up that addressed depression management in this time frame)

3. For the “eight week follow-up”
   a. Is there a documented visit between 6 and 10 weeks following that initial visit in which depression is addressed?
      o Yes
      o No (skip to next chart)
   b. Was the same standardized depression instrument administered during a visit between 6 and 10 weeks following the initial visit?
      o Yes
      o No (skip to Q 3d)
   c. The score of this standardized instrument indicates*
      o Worsening depressive symptoms, including active suicidal ideation
      o No response (no change)
      o Partial response
      o Complete response (score into the mild depression range)
   d. Was the depression treatment plan changed?**
      o Yes, treatments were decreased
      o No, treatment plan continued as initiated at last visit
      o Yes, treatment plan increased (ie referral to higher level of care, increased medication dose or changed medications, added an additional treatment)
      o Unknown (not documented, or no follow-up that addressed depression management in this time frame)

*w/n/p/c corresponds to w=worsening, n=no change, p=partial response, and c=complete remission
** d/s/i/uk corresponds to d=treatments decreased, s=treatments continued, same as before, i=treatments increased, uk=unknown