DAY 1

1. WELCOME & INTRODUCTIONS

Guest Presenters and Guests

- Amy Peterson (Michigan Department of Community Health)
- Kathy Desilets
- Rick Steece

JSI

- Kim Watson
- Jennifer Kawatu
- Michael Chen
- Jessica Ogarek

CDC

- Kevin O'Connor
- Stuart Berman
- Steven Shapiro
- John Papp
- David Byrum

Connecticut

- Gary Budnick
- Susan Lane
- Heidi Jenkins

Rhode Island

- Mike Gosciminski
- Bob Ireland
- Barbara McNeilly

Massachusetts

- Jenny Sheehan
- Lynda Sampson
- Patti Parker
- Marcy Moyel
- Tom Bertrand
- Hillary Johnson
- Arthur Kazianis

New Hampshire

- Jennifer Stearns
- Robert LaChance
- Michelle Ricco

Vermont

- Rebecca LeVasseur
- Daniel Daltry
- Eunice Froeliger

Maine

- Jennah Godo
- Evelyn Kieltyka
- Jemelie Bessette

2. STEVEN SHAPIRO'S CDC IPP REGION I UPDATE

- Budget and funding
  - Steady increase in funding in late 90's, early 2000's.
  - Recently have plateaued with cuts.
  - 2009 budget about $28 million.
  - 2010 President's budget has a slightly decrease for the entire STD program, but HIV has more significant increase – should look for opportunities to collaborate.

- Strategic goals
  - $28 million to 60+ grantees.
  - $20 million leftover funding to fund infrastructure and run regional projects.
  - 7 overarching goals, including prevention of STD-related infertility, with emphasis on screening and treatment, partner services.
  - Other goals cover prevention of cancers, HIV transmission/acquisition, etc.
  - Infrastructure funding and activities
    - Expectations of bodies like JSI (infrastructure).
    - Regional plan, site visits, evaluate, and disseminate data, meetings.

- Where does the $28 million go? (Project area funding and activities)
  - Ensuring CT and GC screening and treatment, etc.
  - Major changes taking place in the upcoming year:
    - **(a)** CDC supports grantees should have the ability to determine program based on its own data.
    - **(b)** The new "50% rule" arose out of the concern about distribution of money. 50% of IPP money for FP - there's now more flexibility to allow FP and STD programs to decide how to distribute that money. The point here is to use your data to determine use of resources and program planning.
    - Only 1 grantee asked for male screening specifically. Most grantees are still trying to expand screening to women.
  - About 3 years ago, male consultation laid out CDC findings on male screening; no guidelines developed as not found to be cost effective across population.
    - Kathy Desilets raises the question of epi data supporting the efficacy of male screening.
      - Stu from CDC responds: Data suggest that male partner treatment is probably more effective, which is why EPT is being pushed. But still much uncertainty over variation in community composition. The data does not suggest general male screening would be helpful towards effectively tackling this problem especially given the way males in the target age group currently utilize healthcare.
    - Kathy asks follow-up question about sequelae in males. No real sequelae in males as there is in females.
  - Requiring grantees to use a % of their funding to target GC screening. This may involve shifting money from low CT prevalence areas to conducting high prevalence area GC screening.
  - Tom Bertrand offers a comment about the lack of support and need for help with resources going to HIV over STD programs, particular partner services. He mentions the need for more help and resources.

- CSPS-IPP 2009

- Calculating GC burden calculation: portion of total IPP funds to be used to target GC screening.
- Steve demonstrates using an example, and clarifies "under 26" is the same as "25 and younger."

- Why GC?
  - GC surveillance graph from 1941-2007, plateaued in the 50's, increase in the 60's, peak in the mid-70's (coinciding with GC control program started by CDC), decrease in mid 90's, plateaued since the late 90's.
  - Rate of prevention is equivalent to rate of transmission. More on this from Amy.
  - Definitive areas in the country where GC is a problem, indicated by the red dots on the map. 40% of GC morbidity is in the southeastern parts of the United States.
    - Pockets of GC in many targeted communities throughout the country.
  - Target population: young women 15-29
  - GC also has huge disparity amongst blacks (when contrasted to non-Hispanic whites)
    - Blacks are 18x more likely to have GC than whites. New estimates show 19x.
    - We're moving too slowly on GC.
  - STD Surveillance Network (SSuN), this is Stu's branch in the CDC.
    - CT just recently joined network. Currently on SSuN Cycle 2, and will progress to 2013. Provides more data on health disparity.
    - 96% of all counties that have at least 15% African-American population have a rate of over 100 per 100,000 (95.6%). Same for whites (0.5%).
      - This is a huge burden of disease amongst blacks, and data shows this cannot be attributed to behavioral differences.
  - We've known this data for a long time, and not much has been done about it.
  - There is only one drug left, due to increased antibiotic resistance.
    - Recent published data of 2% treatment failure in new drugs. This data is based on Japanese studies.
  - So in spite of GC showing plateau, the fact that there's emerging drug resistance to treatment raises a huge concern for our current work on GC (or lack thereof).
    - We need to decrease the burden of disease before the resistance reaches the United States (currently largely localized to Japan/Asia/Pacific Islands).

- Performance Measures
  - Timeliness of treatment for CT (14 days): the range shows for regional and national from 2005-2008. Region I is doing well overall.
  - Timeliness of treatment for GC is also good. In 2008, Region I has a slight drop-off relative to three previous years.
  - Timeliness of treatment for CT and GC also good. Region I is outperforming the national average.
  - GC Interviews, affects 5 out of 6 Region I states. MA gets GISP $ and so is exempt.
    - HMA = high morbidity area. SE = syphilis elimination.
      - Usefulness of old data questionable as each project area set definitions.
      - Kevin raises the question of CDC's interest is in what proportion of GC is getting interviewed. This provides a better measure of programmatic activities in relation to morbidity.
      - CDC also understands that the measurement is not going to be great, but it will hopefully provide more information about the need for additional funding.

- Infrastructure Performance Measures
    - From FPAR data, Region I's FP clinics are doing a better job of screening young women for CT. Still room for improvement.
    - Nationally, it's about 50%.

- Shows graph prepared by HEDIS, with a lot of variability in the data. The graph shows that screening has been increasing since 2000, and Medicaid has an overall higher % than commercial health plans.
    - New England is a top performer in the 16-20 and 21-25 y.o. categories for commercial and Medicaid plans.
    - Steve is also available to provide the NCQA contact if anyone needs it.
    - **(1)** The 50% is an under-estimation of the CT screening work done in FP settings.
    - **(2)** Proportion of tests females 15-24 years. Would like to see this number increase over time, so that we're screening our target population.

- Get Yourself Tested 2009 Campaign (STD Awareness campaign) for CT, GC, and HIV.
    - Partnership with various agencies, including MTV, Kaiser and Planned Parenthood.
    - Rocky Mountain had a $5 to get tested, and they had a 10-fold increase over the span of the two-day service.
    - No positivity data, but would be interesting to see how much disease in the data collected.

3. IPP COORDINATOR'S UPDATE (JENNIFER KAWATU) FROM NEW ORLEANS

- NCC (National Chlamydia Coalition)
  - Yvonne Hamby from Region VIII IPP is IPP representative on NCC
  - Booklet created by NCC for providers, particularly private providers

- Strategic Plan
  - All projects funded should be reflective of the strategic plan, which is a good reminder for everyone to make decisions based on priorities, resource allocation, etc.

- Performance Measurement Data
  - Questions about whether the data are being used?
  - Are the data presented in a meaningful and useful manner?
  - Tom Bertrand asks if other regions are doing a better job at harnessing performance measure data. Performance measure can go both ways in being helpful or not.

- Special Projects (examples) being done in other regions across the country.

- Epi Methods Survey
  - Came out of the epi methods meeting in Chicago.
  - 29 responses overall, 3 from Region I
  - Yvonne Hamby took the lead to do this.
  - Results coming soon and will be reissued for more responses.

- Region I Special Project funded through 2009-2010
  - Continuation of provider assessment.
  - Intervention to improve adherence to screening criteria: provider-level intervention, data dissemination.

4. NCSD UPDATE (TOM BERTRAND AND DANIEL DALTRY)

Tom Bertrand's Update (Advocacy)

- National Coalition of STD Directors
    - Washington DC-based, national non-profit.
    - 65 projects in 50 states, 7 cities and 8 territories.
    - Also include associate members.
    - Primary role: Advocacy on the Hill and support of programs.

- New administration, new budgets coming out.
- Feb. 2009, the new stimulus package came out.
    - Title X got $10 million more
    - Region I has a drop in population, particularly drop in reproductive age women, there's a smaller % of money given to this region in contrast with other regions that have more reproductive age women.
- HIV money ($53 million) might be viable to tap for collaborative work.
- Healthcare reform and where it's going to end up, and its impact on HIV and STD unknown.
- Draft agenda for the upcoming marquee event (meeting) in Washington, DC. Theme is "STD Programs in Crisis," which emphasizes the challenges STD programs face and make it as realistic as possible.
    - Check NCSD website for final agenda.

Daniel Daltry's Update (Program Level)

- Performance Operations Workgroup (POW) and how to improve the programs.
- This year's emphasis is on program improvement.
    - Need to look at ways to improve the programs.
    - Works in conjunction with Performance Measurement Workgroup at the CDC (in collaboration).
- Website development is an area of focus. Overhauling of website is impending with interactive elements built into the website and will be meaningful directors, and provide a platform for technical assistance.
    - Also enables sharing of technical assistance between project areas.
- Kevin added note that it's been a good collaboration between CDC and NCSD. Building an effective partnership.
- Kathy mentions that FP funding is facing threats on a state-level, so it's important to keep an eye on what's going on in everyone's home states.

5. "LESSONS LEARNED IN MICHIGAN" - AMY PETERSON, MICHIGAN DEPT OF COMMUNITY HEALTH, STD DEPARTMENT

- Focus of today's presentation: Cost savings in Michigan, and leveraging the findings here to inform advocacy.
    - Michigan's work as an "example" rather than a "model."

- Provides an overview of CT and GC burden in Michigan, numbers.
    - GC is largely concentrated to the southern parts of the state.
    - Along corridors of transportation (interstate highways) – Detroit, route to Chicago.
    - GC is 25x higher for blacks than whites.
    - CT is much more dispersed, but highest concentrations are still around the same communities.
    - CT is about 9x higher for blacks than whites. Usual disparity stratified by race/ethnicity.

- Quarterly Alliance meetings, which include STD, FM, labs, adolescent health, juvenile detention, etc.
    - Have also contributed financially to help carry out programs, etc.

- IPP Screening Activity
    - Numbers seem to show that the state is doing a better job at capturing the target populations.
    - Ideally, hope that the private sector will be doing more and more of the diagnosing, as the state will not be able to afford to.

- Michigan's budget situation is not promising, as the auto industries are very precarious.
    - Cost saving study arose out of the climate of budget cuts, and the idea is to use these numbers of advocate and preserve funding.

- Funding for IPP Activity
    - STD, FP, and Adolescent and School Health Programs.
    - Goal is to place emphasis (and dollars) on STD testing and services in communities.
    - Mixture of federal, state, and local dollars.
    - But ultimately will still need to advocate so that in the midst of hard decisions, STDs will remain a priority.

- Cost savings analysis
    - Began as a way to avoid cuts during the 2007 budget crisis.
    - Good PR tool for stakeholders.
        - Local health jurisdiction – IPP analysis
            - Number of cases CT/GC identified in the last year, and the number of infections that would have been missed potentially, and apply cost to treat.
            - Sent out letters to local resources to "thank them" for having done X number of CT tests, and then explaining to them that this resulted in saving the government X dollars because of adverting sequelae.
        - Medicaid cost analysis
            - This is more intensive, with slide on "Steps in Michigan's Unscientific Formula"

- Medicaid Cost Savings Analysis
  - **(1)** Using two calculations to estimate amount saved based on theoretically avoided PID at current screening level.
  - **(2)** Cost to treat cases of PID estimated which could have been avoided with 100% screening of eligible patients.

- Amy then discussed the spreadsheet, pointed out the example that in spite of having more 16-20 y.o., more 21-25 y.o. were screened as a percentage of the eligible population.

- About 80% of the Medicaid overall population is enrolled in Medicaid Managed Care plan, which makes the subset population a good representation of the overall.

- Raised the question of needing to spend money to save money, so Amy estimated the cost to diagnose and treat a case.
  - Reimbursement rate for lab and visit fees, etc.
  - In Michigan, the cost to screen and treat 100% of the population is about $4 million, in 2006 Michigan spent over $5 million in treating PID
    - The goal is to increase screening in order to decrease the cost for treated PID cases.

- Question: "How do you determine what percentage of untreated CT cases progress to PID?"
  - Past research has estimated that it is "up to" 40%. Some of that 40% comes from 20-30 year old data. Some research suggests a much smaller # - around 10%. Key word is "up to". About 10% of PID diagnosis is due to CT, but it is not clear what cause of the PID is.

- Very few public health programs have done a cost savings analysis. If Michigan were to do this analysis again they might use lower estimate such as 10% leading to PID, but using 40% has only helped their advocacy so far.
  - They were awarded $1 million (reduced to $750k) for a 5 year screening project. Their analysis predicted that the savings would grow every project year.

- Tom asks, "How did you get this approved? In MA it would be very difficult."
  - The fact that it saves so much money was what caught the governor's attention.

- Initially, screening was going over their budget, so in order do more targeted screening Michigan uses pre-paid forms.
  - If a facility uses all their forms and requests more they will review their allocation based on their positivity. If a facility has a high positivity they will award them more forms.
  - If a facility is in a low GC prevalence area, they do a CT only test that saves them at least $1/specimen.

- Constant Monitoring of Utilization (Lab requests)
  - Semi-annual monitoring, along with re-allocation of surpluses to cover any deficits.

- Couple IPP sites with morbidity of local counties to make determination on screening and whether to make sites CT only or "combo" site (CT and GC).

- Juvenile Detention/Adolescent Health Expansion
  - High morbidity, no regular access to primary health care - increased allocation.

  - Good rapport with school-based health centers.

- Wayne County Juvenile Detention
  - This was a prime target and wanted to make this a major focus.
  - Lesson learned is to get someone who is committed to make this their agenda item.
  - These sites are important especially in the understanding of asymptomatic infection, as 60-80% of males in this population are asymptomatic.

- Establishing a collaborative and ambitious strategy to define the focus and mission of program.
  - Reaching out to non-traditional partners, etc.

- Targeted Expansion – 2009 Pilot Projects in High Morbidity Areas
  - School blitz; teen health centers; Wayne County jail; pregnancy test only; university dorms, FQHC's – STD overflow; Expanded Screening Initiative (ESI) Grants; re-testing; universal male screening in STD clinics.
  - Began each targeted site as a pilot and evaluate whether to continue as pilot wraps up.
  - Sites with the highest counts of GC and CT found call for extra attention in the following year.
  - As a means to address race/ethnicity disparity, the RFP process built-in additional consideration for applicants whose clients constitute over 50% African-Americans given the disparities.

- Steve asks, "How are PTO (pregnancy test only) clients tracked?"
  - Depending on how patients are funneled between pre-natal care vs. FP, and whether the IPP gets lost as the patient gets funneled to become considered as a different stream.
  - Data is fixed from the point of origin.

- Likely Targeted Contraction in 2010
  - Same screening criteria, want to maintain the age limit at 24 y.o. so can continue to target the 15-19 y.o. age category.
  - Expect to have most of the smaller community-based clinics to be preserved in terms of funding, as they have successfully reached out to the community to identify infections.
  - Able to shunt resources to high prevalence sites.
  - Cut low prevalence sites to minimum.
  - Site-by-site allocation as determined by positivity.
  - Medicaid "Plan First!" first billing (cost savings for the IPP program).

- Calling on Our Partners in 2010
  - Adolescent health picking up larger portion of costs.
  - Increasing screening sites.
  - Increasing attention to private sector, understanding as public sector resources come back, it is going to be helpful to extend private sectors to screen and treat, particularly in the Medicaid population as a first audience.
    - Also use local public health partners to increase knowledge and action among local providers (identify areas and specific population groups to target).
    - As public sector pulls back, it is vital to figure out how to incorporate the private sector.

- Tom Bertrand asked about how to handle "dropping sites" while being sensitive to the communication and process.

  - Being clear with sites up front, and not in a contractual way, but in a conversational approach.
  - But determination of how to allocate dollars to fund programs is very much driven by the how much CT there is relative to the overall regional baseline (clearly, targeting areas that have the highest risk).

- Contact info:
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  Michigan Department of Community Health
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  petersonam@michigan.gov

6. STATE REPORT BACK

Maine

- EPT – met with state AG and need approval from Maine CDC to put forth a resolve to request for HHS to work together enable nurse practitioners to dispense treatment to partner.
- Re-screening pilot project started (short term, but will continue for rest of the year)
    - 4 pilot FP sites, if test positive, then can opt-in for text-based reminder.
    - HIPPA rules around testing is complicating things a little bit, as the text does not divulge specific information for testing, site, or CT.
        - A generic "health" message that doesn't convey a very clear message.
        - Low level of acceptance of this method as patients are worried they "won't even know what the message is referring to"
        - More exploration is pending. Region V has implemented a similar process with mixed success.
- Re-screening is at about 42% and has increased over the last 2 years. Outcomes pending.
- Maine CDC putting out: Videos and print materials about getting tested, using condoms, knowing STD status. 3 females, 2 males featured on video message.
- GYT experience: unavailable, didn't receive materials until after the fact. Improving the timing would be a useful.
    - Would like to know ahead of time:
    - What the materials will consist of.
    - Explanation of what the materials are and how to use them.

Vermont

- EPT – Pending – still have a session on budget, pending.
    - Will soon be ready to move forward and disseminate information. Was able to leverage JSI and CDC assistance to disseminate information.
    - Hope EPT will soon be in full effect in VT
- Re-screening project working alongside Planned Parenthood.
    - Working with DIS to call, track, and promote to get them to come in.
    - Direct monitoring/interviewing of the return patients.
- inSpot via internet, targeting MSM population for partner notification.
- Final stages of moving inSpot forward.
- GC trend analysis
    - Focus: Nature of GC and what is in the state.
    - 37 cases in 2008, 64 cases in 2007 – "How did this happen?"
        - Cannot be entirely attributed to DIS, so exploring possible causes.
        - Significant amount of is "imported."
- GYT experience: have materials earlier to help get hurdles over state infrastructure.

New Hampshire

- EPT is in transition; some issues within the state and figuring out how to move forward.
- Next step is considering how to extend network to include more external partners, like the presentation about using an "alliance" format.
- Giving a "report card" to sites to help them get a better sense of what the numbers are and also re-screening.
- Improving internal communication to reach external partners.
- GYT: very minimal work was able to be done.

- Take-away: how to re-build internal infrastructure and work as a group. Transition from after Drew left.

Massachusetts

- EPT has faced starts and stops.
    - Kathy Hsu gave presentation to the Massachusetts Medical Society, but many providers expressed concerns about liability issues. Some providers are very uncomfortable with EPT.
    - Considering taking another route: work internally and see if it can be added to the budget.
- Taking a look at GC testing, where it's being done, and positivity rates
- GYT: huge disappointment. Unsure if GC, CT, and HIV testing all done is best use of resources for young women. Would like to see more incorporation of STD testing promotion in HIV testing days/months as well as incorporation of HIV in STD testing "month" materials.
    - Did not receive materials until the month of, so hard to get it going immediately.
    - Established presence on social networking media.
    - Focused on colleges in the state; targeting providers at health centers at colleges.
        - Fact sheet on CT, references to state and national websites, etc.
        - Prevention training centers listing classes for providers to conduct STD testing, so providers can become familiar with STD screening protocols.
        - Student organizations reached via e-mail blast. Parallel mailing.
            - But April is toward the end of the academic school year. So it wasn't that effective, but it does lay groundwork for the fall – health fairs, etc.

Connecticut

- EPT: has gotten commissioner buy-in to include some language into an existing pharmaceutical bill.
- Tried to get the medical board onboard, but board is unsure.
    - Concern over who will pay for medication when people go to pharmacy. Did this pose additional financial obligation on HUSKY (state insurance program)
    - Will continue to try for this.
- Will begin to look at most of the performance measures/goals and objectives.
    - Should be able to meet the 90% within 14-days.
    - At about 18% currently to get the re-screen within 3 months. Working on improving this.
- Pilot on reminder form for re-screening: normal, letter, and phone call. Around 217 people were sampled.
    - But actually got the most show-up in the no-reminder group. Is the reminder turning people off?
    - The letter showing a slightly better response rate.
    - Cellphone issues also, especially for young people, who often change numbers due to affordability of plans.
    - No correlation between money and race on return visits (i.e. someone owing money will still just as likely come back).
        - Went to best and worst re-screen rate sites to conduct focus groups.
        - Turns out that people who make appointment the day of their visit shows the highest likelihood to keep the appointment.
- Added 3 more sites located in high rates of STD that don't have much visit.
    - 25 and under only.
    - Considering adding PTO, but would need to change lab slip.

- GC test cost went from $10/test to $96/test. Very dramatic change in cost of test.
- GYT was well-received.
    - Had nothing to present until April when started preparation in January.
    - Put out information to those who have been given testes before.
    - Declared 4/22 as GYT Day Connecticut.
    - Promoted the event on local and college radio stations. Health communications group in the health department is doing really good work. Creating PSAs and reaching out to students and communities.
    - HIV Division offered HIV test kits.
    - Colleges and universities promoted on their own. Many people showed up, and the fact that it's a free test attracted many students. Did not find disease, but was successful in creating awareness and felt successful about this.
- Steve explained the fact that the hold-up was related to the April 1 release date which was dictated by MTV and Kaiser.
- Gary added that increased testing was done. Lab was able to handle it this time. Believes in the value of promoting a GYT Day, but needs to coordinate the distribution of the test better and volume considerations.

<u>Rhode Island</u>

- EPT update: support from medical and pharmacy boards, there is a document draft in place, but still trying to push that along.
- Hoping to work with the Providence CHC to pilot EPT
    - Was told that could not do EPT at this point, partially due to federal guidelines.
    - Considering creating a more robust referral system.
- Changed screening criteria: from 24 and under to 25 and younger females. Does not complicate state lab, and also in compliance with CDC.
- Working to open up IPP to all Title X FP sites, except maybe one.
    - Thundermist changed its lab to Lifespan, so could no longer obtain lab results smoothly.
    - Newport VNS closed down, so no longer part of IPP.
    - So now open to all FP sites and see what sites might be interested.
    - July 1, 2009 is a tentative deadline, but swine flu has caused some delay in getting sites onboard.
- Loss of Thundermist as part of the data collection has impeded data collection.
- GYT: did not do much with this campaign.

7. REVIEW OF CT DATA (SUSAN LANE)

- New technology: Genotyping CT to determine if it's the same strain as what was detected during initial infection.

- Study found that women encounter difficulty while discussing CT issues with sex partners. Many were infected with different strain – i.e. not reinfected from same (untreated) partner but often is reinfected with another partner.

- Yale study on how to increase CT testing for men – focus groups with teenagers, peers, etc. Findings:
    - Men don't know what CT is.
    - No serious sequelae that needs drastic medical attention.
    - Motivator: ease of testing, simple treatment (cure).
- Also looked at cost effectiveness and how to distribute this message to get men to receive CT tests.
    - Turns out that Facebook is an effective medium, using Facebook's profile to create target-specific users with ads (cost-per-click charge). Besides being cost-effective, also offers insight into users' behavior and profile.
- Another medium to distribute: public transportation, as teens report spending a lot of time on buses.

8. PROVIDER ASSESSMENT METHODOLOGY

- JSI was awarded $10,000 to conduct a provider assessment.
- Our goal was to get an understanding of reasons for non-adherence to screening criteria.
- Our assessment will continue on to 2010 JSI was awarded additional money to develop an intervention to increase provider adherence.
- The assessment began with key informant interviews to gain an understanding of provider's knowledge of screening criteria, attitudes, and of the IPP project.
- A survey monkey survey was created based on these key informant interviews. The survey was rolled together with an HIV survey because both survey's had the same target audience to avoid survey fatigue.
- There were 302 respondents, 75% were from our target audience.
- We asked for both IPP and non-IPP respondents. We wanted to know if there was a difference between IPP and non-IPP in terms of screening criteria.

Preliminary findings

- We found that 30% of the respondents are using EMR's, which is encouraging and these sites may be used for some increased data collection that we cannot otherwise get easily.
- 38% of respondents did not know if they were part of IPP.
    - Some people might not know what IPP is because they are calling the project CP – Chlamydia Project.
- Providers estimated that their positivity was 10%.
- Screening practices do not match CDC recommendations for all respondents. When looking at only IPP sites, the screening practices still do not match CDC's guidelines.
- When asked about the CDC screening – the majority of respondents could not correctly identify what the guidelines were.
    - Less than half of clinicians (even MD/NP level) are unaware of what the guidelines were.
    - Kathy mentions that many FP providers are confused about what the guidelines are because there has been a push to screen men. There are no guidelines like there are for women –
- For re-screening – the majority of respondents (68%) asked patients to come back 3-4 months after positive test.

Pregnancy Test Only

- The survey included some PTO questions.
- A substantial number of respondents report doing PTO screening.
- Only 10% of respondents said they don't have time to do STD testing during a PTO visit.

Q&A

- It is concerning that so many people have different standards of practice.
- Did JSI test the questions with target audience?
    - There was a committee that tested. The key informant interviews tested the questions. There was not a formal pilot test of final survey outside committee.
- What other things would you like to see for analysis?
    - By state – the people that know the guidelines, where they get their information, and what role they play in the clinic (By State – broken down by provider type).
    - Did you ask how long they were at the clinic? Results could be because of poor training, or providers that use old terminology ("test of cure").
- The branding of IPP might have confused people. Many folks say, "Chlamydia Project"

- Is it important that they know the information comes from IPP? Or is it more important that they know what the screening criteria is?
    - Knowledge of screening criteria could use improvement, and in the process we could raise awareness of the IPP project.
- In ME, with the lack of funding, they have been trying to un-couple IPP with screening criteria b/c they think that since they don't have IPP $ they can't screen.
- There is one message here – there is info that is not adequately in the field. The next step is what do we do about this? What can we do to disseminate information?
- Phase 2 of this assessment is asking everyone how we can improve knowledge and awareness around CT and GC screening. We want to develop (with the AB's help) reports that show progress and benchmarks. Most of the work we do with IPP is at the regional level. We want to get down to the clinic level.
- Provider awareness campaign: Possibly print materials
- Suggestion to investigate: Interactive E-Learning/online course for clinicians to help clinicians learn the guidelines.
    - Project directors in ME have given feedback that they love webinars to get information.
- Region VIII developed a guideline "cheat sheet" that has all the criteria that is laminated. Many states reproduce the CDC's guidelines into small laminated cards.
- The big question is do they not know the guidelines, or do they know but ignore them? Closer analysis will try to answer this for the survey respondents.
- Materials are hard to filter through clinics. E-learning is much easier to distribute.
- Where do we interface with sites? Meetings, news letters? How do we re-enforce information?
- Many EMRs have templates that automatically assume screening within criteria.
    - It is hard to change those templates, especially where you fall on the priority list. IPP falls very low on this list, and it is hard to make changes to those templates.

- **Volunteers for work group for provider assessment: Tom, Mike, Daniel, Jennah, Evelyn, Roberta**

9. CDC STD LAB TESTS 102 (RICK STEECE)

- Cell culture has the highest specificity.
- Last state not using NAATs just recently sent out a bid for proposal. Everyone else in the project is using the NAAT test.

- "Sensitivity" – ability of a test to detect pts who have the disease or condition for which they are being tested.
- "OR" refers to the proportion of ppl with disease who have a positive test.
- "Specificity"
- "Positive predictive value" (PPV)
- "Negative predictive value" (NPV)

- Shows table showing NAATs as having the highest sensitivity and specificity (relative to those of culture).
- Assay sensitivity has a minimal effect on negative predictive value (as shown by graph) – in other words, negative will likely ("pretty much") remain negative.
- Effect of repeating specimens: sensitivity remains the same, but the specificity is revised. Positive results become more likely to be a true positive (statistically speaking).
- To address issues of residual DNA or RNA, 3 weeks after successful completion of appropriate antimicrobial therapy.

- Question raised about re-infection and whether if at 3.5 weeks (after completion of treatment), could it be residual (due to remaining antigen) or re-infection?
- Based on best information available, it would most likely be re-infection.

- Please refer to Rick's slides for full presentation (available on IPP's website: ipp.jsi.com).

DAY 2

1. FINAL LOGISTICS, SURVEY EVALUATION, ETC.

- Date for the November meeting (in Boston MA):
  - **November 12, 2009**

2. RICK STEECE'S LAB 102 (CONTINUATION FROM DAY 1)

- Please see previous page, as notes on Rick's presentation have been consolidated together.

3. LAB UPDATE FROM JOHN PAPP

- Talk is based on a consultation given to CDC, the consultation brought a variety of different backgrounds together.
    - In order to develop guidelines, John wanted to make sure to select an audience consisting of public health directors.
    - Identify gaps in knowledge and look to further it via revision with evidence to support.
- Meeting summary:
    - All culture and non-culture tests may generate false-positive results.
        - Important for clinicians to understand this. The lab should also communicate to the clinician that there is always going to be a chance of a false positive.
    - NAATs have superior performance to all other tests.
        - No change from the 2002 document. Research continues to support this. Best way to detect GC and CT.
    - Culture is still useful in certain circumstances.
        - This can still be useful.
        - Detect mutant strains.
    - Serotology
        - This is a new addition to the document (it was not included in the 2002 document).
        - Not much utility due to cross-infection.
    - Direct Detection of LGV.
    - Need for additional data.
- Vaginal specimen collection can be done in healthcare setting collected by either the provider/clinician or the patient herself.
    - Home collection and sent to lab via drop-off site or mail – FDA has not cleared this yet.
    - CLIA and CMA is concerned about transportation of specimen from collection site (home, field, healthcare setting) to the lab: temperature.
        - Utility of this function is particularly useful in remote settings.
- Jennifer raised the question of during key informant interviews of the provider assessment, all 8 respondents did not distinguish between vaginal versus cervical specimen.
    - John agreed that vaginal swabs are preferred, especially when coupled with reliability and potential for expansion (i.e. sample collection at home).
- For men, urine specimen is the preferred type.
    - Swabbing the end of the penis as a method is too early to determine whether reliable.
- Tom asked about preference for combo vs. single test.
    - Combo vs. single are comparable.
    - Specimen type is the same between urine and vaginal swab.
    - But believes that this is a programmatic question, rather than a lab question.
    - Advised that if making this transition from single test to combo, need to communicate this to the lab people ahead of time so that they will know what and how much to stock.
- Tom is seeing low amounts of GC after recently rolling out combo tests in Boston's school-based health centers.
    - John recommends testing the CT via single, and then reflex testing as a pool for the GC.
    - No real impact on cost.

4. NATIONAL CT DATA PRESENTATION (STEVE SHAPIRO)

- 2007 Surveillance Report and CT Supplement
  - Different screening criteria variation by region.
  - CDC recommendation is women under 26 be screened annually.

- Disparity amongst white and black in CT is increasing (about 11-fold currently).
- Target population is vastly dominated by 15-24 female group.
- Vast majority of cases reported come from non-STD sites (including public and private providers).
  - Definition of "private" provider is not very clearly or easily defined.
  - Coming out of this, if can overlook reimbursement and payment issues, there is not a huge benefit for differentiating "private" provider from everything else.

- From the national database:
  - Conducted over 3 million test records in 2007. Includes only positives and negatives ("insufficient" tests are excluded).
  - More regions are moving towards using NAATs as the way of testing.
  - CT concentrated around southeast and southwest, along with Texas.
    - Plausible explanation? Maybe evolving screening criteria.
    - Positivity trends among 15-24 y.o. have remained largely stable from 2003-2007.
    - There has been a slight increase in positivity over the past 15 years. This could be due in part to increased sensitivity and test technology.
    - This increase in positivity is not necessarily an increase in prevalence. There are more factors to consider – such as changes in tests, changes in population, etc. Look at the data and put it in context.
    - Population based prevalence is going in the opposite direction of positivity
    - It is a statistically decreasing slope. The CDC's statisticians do not want to make an assumption about why it is going down. Next year's data will be available in a few months that could show something different.

  - In reality – Why is the prevalence so different from the positivity?
    - It could do with screening criteria. We are not at 100% screening coverage. The data also has different clinics year to year, so screening criteria changes.
    - In ME, they use the same clinics, the same physicians but positivity is going up because of increased targeting
- Summary (see slides)
- Regional behavioral risk data – who collects what and how is it used?
  - Variables are not uniformly collected by all regions across the country.
  - Even the same variable is not collected using the same specific set of criteria (e.g. same variable but different time frame – 30 days vs. 60 days).
  - Essentially, there is no single behavioral risk factor that is consistently collected by all regions across the country.
  - Core variables are standardized across the country, but the "enhanced" variables are not uniform (making it hard to compare).
- Use of behavioral risk data
  - Very limited usage, unfortunately
  - Only regions 9 and 10 were able to collect behavioral risk data from all their grantees to help inform program activities.
  - No other regional use; if used at individual state level only.

- Tom is interested in knowing which of the behavioral risk factors are predictors for CT infection (which was also alluded to during the cost study discussion).
- And from there, this can be good for educational purposes and also for more selective screening criteria.
- Steve suggests for Holly Howard to come and speak more about this issue, possibly during the November IPP meeting.

5. REGION I DATA

- Will be sending out facility verification information to ensure that all the sites are accounted for.
- Review of each objective with data to support.
- Quality of data
    - Data being submitted are of good quality, which is very helpful.
- Except MA, all of the states are doing combo tests.
- Summer activities – selection and definition of facilities, data triangulation.
    - Figuring out how to set a unique identifier that follows a patient as he moves through the healthcare system.
    - Will involve everyone, particularly the family planning partners.

6. SUBCOMMITTEE REPORT BACK

Lab (Bob Ireland)

- Meeting regional objectives, self assessment feels like doing an excellent job.
- Wording in obj. 3.3 was changed from November meeting.
- Analysis on 2 studies:
  - Time from specimen collection to arrival at lab – 95% within 6 days, 60% within 3 days in the objective. Came pretty close to accomplishing this goal.
    - Identify the "repeat offenders" who do not meet the transit goals.
    - Several community health centers in RI were off – some were as off as by a month.
    - Resolution: will draft a letter as a group and send out to all clients and remind expectations and what the group is trying to achieve + follow-up individually with the "repeat offenders" to ensure better compliance going forward.
  - Turn-around time study ran from 5/4-5/8.
    - RI came up a little short on the 3-day, but otherwise generally everyone did a good job of meeting this objective without encountering great deal of difficulty.

- Obj. 4.1 – reproducibility study. Repeating 100% of all the positives.
  - Since guidelines have changed, no longer requiring 100%, the group will modify the objective and conduct repeating based on taking a closer look at deviations.
    - Will provide follow-up in November meeting and update.
    - Note of some labs demonstrating inertia due to having performed protocols the same way over a long time – resistance to change.

- Also will talk to sales reps to determine sales per test, volume, and see what we are paying regionally. Strive to get better pricing on par with what everyone else (presumably in the country) is getting.
  - Will share information with us for the purpose of cost analysis.

Lab/Data Subcommittee (Evelyn)

- Follow-up from November meeting – lab slip and re-screening (making data available). Will get back to JK on:
  - Existence of unique identifiers attached to pts who come in from CT screens, and whether this could be tracked. This would constitute a first step.
  - Lengthy discussion about gender/trans-gender issue:
    - An emerging issue with several pilot projects going.
    - Modification of history forms to capture other gender options.
    - boils down to two options:
      - **(1)** This is not something that we're going to change the lab slips at this time, but we may include a statement.
      - **(2)** On a regional level, reminder of being sensitive and awareness given this emerging issue via discussion at the national level.
- Regional uniform data points
  - Possibly regression analysis of risk factors
    - Each state needs to collect risk factors and consider validity of data
    - November meeting will involve a lengthy discussion of risk factors and determine whether each risk factor should be preserved or updated.
- Date for the November meeting (in Boston MA): **November 12, 2009**