ATTENDING

Guests
- 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
- Heidi Jenkins

Rhode Island
- Mike Gosciminski

Massachusetts
- Tom Bertrand
- Hillary Johnson
- Katherine Hsu

New Hampshire
- Robert LaChance

Vermont
- Daniel Daltry

Maine
- Jennah Godo

1. KEVIN O'CONNOR

- Context: Hard times leave us with funding reductions and a decrease in opportunities, etc.
- But also realizing that it's important to continue doing work around GC amidst the tough climate. Examples from Region IV: discussed work being done by community-based orgs, family planning, education, inner tent city, working with private providers in key areas, incorporate GC into existing activities, regional visits to providers and regional partners, GC/syphilis co-morbidity, partner services (DIS, EPT, referral cards).
- Intention is to engage STD directors in discussion; facilitate peer-to-peer learning; explore regional similarities (morbidity, resources, infrastructure, populations).
- Also has a one-page "needs" document to capture any needs specific to working with GC: money, staff, TA, etc.
- Heidi Jenkins asks about TA grant opportunity for partner services. This is a resource for HIV and STD programs.
    - Emphasis on making partner services specifically as an area in which collaboration occurs.
- Meeting objectives (see slide)
    - "Cost-neutral" as a point to do a better job with existing interventions with the same resources/funding allocated.
    - Some pressure to do more with fewer resources.

<u>"GC Control: A Historical Perspective"</u>

- Why now? Profound health disparities; opportunities to reach at-risk for GC, to learn from historical success (e.g. female screening program which resulted in GC rates, female, dropping for two decades). Also concerns about drug resistance.
- GC Control Program occurred between '72 ($16 million given by Congress) and '94, saw decrease in GC rates. GC control did demonstrate success.
    - Began largely as a screening program for asymptomatic women. Included partner services.
- Almost 5 million tests conducted in 1973. This was a robust screening program.
    - Out of the 5 million, 4.9% were positive.
    - Historical records available: 64,000 interviews for GC took place during April-June 1973.
    - Contacts: 61,439. Roughly 1 contact per case.
    - Infected/treated: 15,928 (.40). This is a comparatively high number relative to HIV. Provides indications for the importance of reaching these people.
    - About 64,000 new cases per year.

- Program components and other sources to overall morbidity
    - Partner services (64,000; 7%); targeted screening (242,000; 29%); STD clinic (109,000; 13%). About 842,000 cases reported in 1973.
    - To have an impact on the overall case load, must have significant portion of cases found through different sources. A mixture.

- GC in Pittsburgh
    - Allegheny County serves as an example of a GC program (see slide).
    - Male GC interviewing, broken down by quarters.
    - GC incidence by sex shows about the same number of female cases, but male cases were dropping. Why? Maybe symptomatic males not coming in.
    - 1993, 1994, 2000 all show decreases in # of GC cases and # of tests.

- Decline in GC due to several factors (see slide).
- Screening strategy showed drop in GC rates as program was implemented, BUT GC rates were dropping nationally as well, thus making it difficult to establish cause.

- Partner services: who should you interview, and how much is enough? 5% of cases? 25%? 50%? 100%? At what point would have impact on morbidity? No clear answers.
    - Tom's comment: asks about the unclear position between different experts/literature on whether partner services is an effective way for preventing GC (as it has shown to be effective for syphilis) transmission.
- GC Control Strategies (see slide)
    - Much of it surrounds partner services.
    - Hillary's question: asks about the existence of computerizing data (STD MIS) and the results of the interviews.
        - Stu mentions the example of what Florida has done, but suggests that it is difficult to manage a relatively rare disease (i.e. not as prevalent as HIV or CT) while improving the system to efficiently address this issue. Data systems? Operations? Learn from each other? What resources are available on hand?
        - Steve says that perhaps it's not so much a reliance on software or technology, but rather this work can be done manually (by hand). Developing a system to process information via a "line list" on a regular interval. With smaller numbers a software solution may not be necessary.
    - Hillary's follow-up: asks if CDC is in the process of developing some sort of system to improve efficiency.

- MMWR Recommendations on partner services – "Prioritizing GC infected persons from core areas might offer an opportunity to reduce transmission on the community level."

- Heidi asked Kevin to give more background on the Pittsburgh program.
    - Program was already established when he arrived. Well established courier, lab, transport, incubator jars, transportation, culture, etc.
    - "Awful lot of testing" was done especially considering the time. With changes in cost, technology, etc., much has changed.
- Jennah asked about whether any examples involving a more rural setting, as urban environment is less applicable to her locality, particularly the screening aspect (the interviewing portion is less of a concern).
    - Kevin mentions the work done by New York state as a possible example.
    - Steve mentions Region II showcased this information recently.

2. STUART BERMAN

Why Talk GC Now?

- We are in a very different place in time when it comes to GC. Very little information about STDs makes it to the news. We are "fighting the fight" but we aren't seeing much success.
    - We have reached success with Syphilis.
    - We have seen success with lowering CT rates (with a slight upward trend).
    - Over the past 10 years GC positivity has hit a plateau.
- It has been a difficult decade
    - Many resources have been dedicated to Syphilis control
        - It is unlikely that more resources will make any change in Syphilis
    - Considerable resources have been dedicated to CT
        - There is a HEDIS measure for CT, but there are no screening criteria for GC
        - Control is challenging – rates have been increasing internationally. We are looking for the right formula.
        - As will Syphilis, it is unlikely that more resources will have any impact on CT control.
    - What about GC?
        - Few resources available for GC control
        - Health departments are not targeting GC testing. Screening is happening, but more work needs to be done.
        - There is a large racial disparity (19:1 = B:W) 70% of infection is in African American population.
        - A small effort will have a large impact because very little is being done.
        - Incidence is much lower than in the past.
        - If we can shorten the duration of infection we can prevent the number of people who the disease is transmitted to.
            - If we increase screening 20% we could see a large % of reduction. Transition models the show the relationship between activity and rates are not linear.
        - If you know the population and you know the location – how are you delivering services? How do you deliver your "product" efficiently and effectively?
            - GC might help us learn how to do business better. It could give us better knowledge on targeting and prevention to see lower rates.
            - Can we learn from GC – a disease that is not tricky to solve, the tools have worked well, and has had success in the past. It needs better targeting and better use of resources. This does not mean taking on more work.
        - Katherine – A simple target is women b/c they have more infection. A subset of IPP $ is putting toward GC, and we should be targeting geographic regions with higher prevalence.
            - There may be ways to leverage resources. Medicaid does screening
                - Katherine – MassHealth often does not pay for these tests when asked.
        - Tom – There is an assumption that the answer is a medical model. At some point let's talk about behavioral changes and prevention (using condoms, etc). We should have a conversation about inclusion of behavioral interventions.
            - You are going to need buy in – and it won't be GC only, CT only but whole sexual health.

- Kevin – In the 90's with HIV there was a large behavioral change to use condoms. Current assumption is that a medical model will be the answer.
- How much effort is going to be put in – Sex ed in school, etc. If you want to reduce population levels how much effort, how much are you going to put in to it?
- Kevin – The outcome of a heath disparities meeting 2 years ago was that the African American population wants more of a focus on sexual health than disease-specific interventions.
    - You also need to have an idea of what you want to accomplish. You want to make sure they are getting better services and care.
- Tom – In our role in health departments, what should be our primary focus?
    - Maybe defining what kids should know and working towards that in the community.

<u>A Framework for GC Control</u>

- We spend a lot of time talking about the ground view.
- It is useful to look at GC as a way to approach STDs in general.
    - We don't have a benchmark for GC. We do different things and hope that the rates go down. When the rates go up, nobody knows why.
        - If we want to see the rates go down in the next 10 years we have to be more targeting and work in a more quantified way. We shouldn't be surprised if we aren't seeing much progress
        - Where do you start? There are many pieces that go into screening – labs, tests, risk behaviors, etc.
        - There has been success in GC control in the past, so we should look at what they have done.
    - The bottom line for screening is who is getting screened and who should be. How are you going to know who should be screened? Start to think about how to identify opportunities for improvements.
        - We need feedback from the epi approach , what are the opportunities for improvements
    - Just screening is not enough. The second component is treatment.
        - Unlike CT, a high % of men have symptoms. The easiest way to treat GC is to treat the symptoms.
        - There should be community buy in because they want to improve the health of those that are not receiving care.
    - The bottom line for treatment is who is not getting care. Who has been diagnosed but not appropriately treated. What can we do about this?
        - This has the greatest room for improvement because no one is doing anything about this.
    - The third component for GC control is partner treatment
        - It is important to reduce the barriers to get people in to care
        - The bottom line for partner treatment is which partners are most important to care. How do you get the greatest number of people treated quickly with the least amount of effort.
    - A forth component to GC control is Community Engagement
        - It can't be just about GC, but STDs and sexual health as a whole
        - How to get the community aware of STDs – signs and symptoms. It is less about accessibility than it is about acceptability.

        - The bottom line is that improvements in other areas rely on improvement in community engagement. Many people doing a little bit will have more effect than one person doing a lot.
    - Surveillance and Program evaluation
        - How often have we looked at the PM performance? What is your screening coverage, partner treatment in the areas that have high prevalence? Use the data to target.
        - We have not evaluated program effectiveness because we have not had to do that. As long as your rates are going down, does it matter if another health department has lower rates? No, what matters is that rates are going down. We have never had to do this analysis, so we have no tools, training, etc to increase performance.
        - The bottom line is what you know and what you don't know about your performance. How do you make this part of your yearly approach and how do you learn from each other.
        - What do we do about where we are? How do we be a more engaged partner to help make this happen? How do we develop new attitudes and tools.
        - Kevin – Across the US, if we dissect where the morbidity is and what is going on in those communities it is more manageable.
        - It takes time to make changes – it doesn't happen right away.
        - Jennah – A lot of the points made are things that she has thought about. It is encouraging to think outside the box, but some of the approaches are not what is best for ME. It is good to ask these questions, and perhaps look towards the communities and put sexual health on their radar.
            - Jennah – Right now not all of these issues are on the radar, even though they are important.
        - Kevin – Had a discussion with program consultants about what they are doing about GC. Everyone was doing partner services. You don't have to have a huge program, you just have to focus on where the morbidity is. Does it help provide clarity?
        - Daniel – We look at screening first – Do we increase, do we target? The next default is partner services, but we need to look at all 5 components. These concepts are easy to tweak for VT to target and get better results. This is a clear roadmap.
        - CDC gets asked a lot why rates are up. It is almost always the case that they can't say why. There is no data to determine. To make prevention work you don't need to know. You don't have to do everything, you just have to be efficient.
        - Jen – There originally was discussion that maybe we should only have this meeting with the higher prevalence states -
            - However, this approach works for all STDs, even if this is not applicable to GC in your state. And all states have some GC. All STDs are in the same place.

3. STUART BERMAN (LORI M. NEWMAN, MD) DIVISION OF STD PREVENTION, CDC

"Application of an Epi Profile: Gonorrhea in the U.S."

- Defining an epi profile and its practical uses. Most important is to help inform the process of public health decision-making.
- Framework including elements such as what, when, how, where, etc. (see slides)
- Moving away from the "silo" mode to a more efficient public health system.

- GC rates cluster in the South
    - Not as high in Region I; the region is predominantly white.
    - Almost a straight line can be drawn across the United States with African-Americans clustering being very evident.
- When GC positivity, women 15-24, FP clinics, by race, Missouri 2001 shows such a disparity between whites and blacks, it is almost impossible to come up with a screen criteria. So how to ensure that the population is screened properly?
    - Create operational definitions.

- GC rates by county no longer clusters only to the South. It is almost pervasive throughout all parts of the U.S.
    - Counties in which more than 15% of population are black, GC rate is 96%; in contrast, counties with more than 80% of population are white, GC rate is 1%.
    - So how to create screening criteria that are not race-based? Again, difficult. Race can be introduced as a "factor," but making it into a "criterion" is difficult.
        - But it is possible – community-based decision-making can be a very helpful tool.
        - It is not deemed as acceptable to create race-based criteria, unless they originate from the community.

- Identifying contextual factors (see slide)

- Tom's comment: The data set used in the presentation does not include data on black and Hispanic youth. Mentions that it seems like a double-standard when compare to the discussion centered around MSM and willingness to identify behavioral risk in order to create effective interventions.
    - Stu states the data show it's not due to difference in risky sexual behavior. It is like to be due to other factors that ultimately result in the disparity. When behavioral differences are accounted for the disparity remains.
    - The question becomes how to change from a community level.
    - How to communicate this message?
    - How to tell individuals that their baseline "normal" behavior puts them at a higher risk – so how to communicate this?
- Kathy's feedback about why there is a difference between the message being given to the community vs. message given to MSM populations. She thinks the message makes sense and should be given.
    - Stu thinks there's a limited capacity to what and the amount of messages communicated to the community and getting buy-in from the community.
        - Involving the burden of disease in the community, looking at data both from national to state level.

4. VERMONT STATE REPORT: DANIEL DALTRY

- 23 cases of GC in Vermont in 2009.
- Historial rates: 72→63→37 – GC does not seem to follow a predictive trend in GC prevalence.
- Historically, VT has a low incidence rate of GC.
    - Not much of syphilis to really work with it; at the same time, CT is not small enough to be easily managed.
    - GC is a good medium to do closely followed work with calling people on the phone, etc.
- Strong partnership with Planned Parenthood and other providers.
- Cases are given priority for field interview, with results reported soon after.

- General trends: CT shows a parabolic move, with a little blip attributable to NAAT's being implemented during that window period.
- Trend of GC not following CT.
- With introduction of test that offers greater sensitivity and accuracy, GC rates went down.
- Age group of 20-24 is most common for GC. 25-29 y.o. most recent; this does not follow the more common 15-19 y.o. group.
- VT's race composition does not include many minorities; majority is white. Small numbers.
    - Blacks contribute to 0.5% of the state's population.
- By identified risk profile:
    - MSM is not the most prominent.
    - Heterosexual men and women show most GC cases.
    - AA over-represented
- Interview Productivity table
    - Given small number of cases of GC, the DIS index number ought to be higher. Calls for the state to improve its effectiveness. But at the same time, this measure is also influenced by the number of cases detected.
- Overall VDH productivity
    - The impact demonstrated by partnerships with GC
    - VDH brought in almost 100% of the contacts (individuals interviewed, brought to treatment) in the state of Vermont.
- Data are collected and entered into MIS during the initial interview, which allows for tracking.
- Heidi asks whether the 6 cases of GC were connected – appears that 2 of them were connected, and the remaining were not.
    - But no data on whether the 6 cases were "home grown" or "imported."

5. RHODE ISLAND STATE REPORT: MIKE GOSCIMINSKI

- Reported cases of GC in RI 1940-2008 graph shows big variation.
- GC by sex: switch occurred in the mid 90's as more female cases emerged.
- 19-24 y.o. category has the most (proportionally) cases of GC.
- Provides an overview of the department and program staffing.
- DIS In RI:
    - Infectious syphilis is 1st priority, followed by GC.
- GIS mapping
    - Allows evaluation of evaluation's performance/efficacy.

6. NEW HAMPSHIRE STATE REPORT: ROBERT LACHANCE

- The only service HD does r/t GC is partner services.
- Low prevalence state, but also with low staff and resources.
- 21 counseling and testing sites throughout the state, incorporated into local health departments, FP sites, community health centers, etc.
    - Site located within 1 hour drive from anywhere in the state.
- Data is impending and will be posted on website (see slide).
- GC by gender: more females are getting infected.
- GC by year and age: 20-24, along with shifting from male to female for most infected.
- Manchester and Nashua are two most populated cities in NH, and about half of the state's infections are in these two cities.
- Data tables are transitioning from percentages to rates (in progress).
- GC mode of exposure:
    - Transitioning toward heterosexual women in 2008, from mostly MSM in early 2000's.
- Trend changes (see slides)
    - Currently being re-organized into another bureau, as dictated by DPHS. Unsure of the near future and what changes might take place.
    - The approaching change seems to convey more structure than what has been done.
- Steve asked about NH's statue about age.
    - If the partner is three years older, then reporting will occur and follow-up may occur. But not mandated to report.

7. MAINE STATE REPORT: JENNAH GODO

- GC "outbreak" in 2003, with steady decline since then.
    - Except Lewiston, most cases are centered around Cumberland county and Bangor. But mostly in Lewiston and Portland.
- 96 total cases in 2008.
    - 89% assigned to DIS for interview
    - 91% interviewed
    - 64 total partners initiated
    - 35% with no partners
        - Of those with partners, 38% were infected.
    - Affected in greatest numbers: 20-29 y.o. group
- From Jan-May 15th, 2009: 57 cases
    - 15 cases found to be connected (white females naming older black males in two specific geographical areas).
- Conducting the combo test.

- Challenges:
    - Small numbers for target groups – how to target populations effectively?
    - Lack of resources.
    - Small disease numbers.

DAY 2

1. MASSACHUSETTS STATE REPORT: TOM BERTRAND

- In the past ten years, CT cases doubled, and syphilis cases have also increased. But GC has remained fairly stable (much less movement in # of cases).
- Male-to-female ratio is about 1:1.
    - MSM has not brought any skewing effects to numbers.
- "Hotspots" for GC cases exist throughout the state: Boston (783) and Springfield (285). Followed by Worcester and Brockton.
    - Big drop-off after the top 2. Boston and Springfield have much higher # of cases.
    - 20-24 y.o. group has the highest incidence over the past 10 years.
        - All age categories show similar trends.
- GC incidence highest for blacks, and disparity by race/ethnicity is increasing.
    - In the last few years, although numbers are decreasing, the differential (gap) between blacks and whites is increasing.
- Quinolone resistance in GC isolates.
    - Indication for resistance for GC in the field.
    - Helps to keep track and see if follow-up phone calls are needed.
    - Over 90% of the isolates are in predominantly gay men.
- Partner services for GC is not a priority.
    - Numbers shown are mediocre.
- Quinolone resistance and infectious syphilis are the priorities.
- In terms of access to care/accessibility of services, there are four STD clinics (diagnosis and treatment) and several HIV counseling and testing sites (diagnosis only). Tests HIV, CT, GC, and syphilis.
    - Huge challenge arises in having to refer out to the only four STD clinics (Pittsfield, Fall River, Boston Medical Center in Boston, Mass General in Boston) for patients who are screened and given diagnosis in the other sites throughout the state. But have no access to Treatment.
    - Uncertain of future after July 1st, 2009. Funding for STD Clinics is cut.
        - If no insurance, it costs about $80 out-of-pocket for patients.
    - Jennah asked about possibility of having the clinicians travel to different sites.
    - Jennifer asked about whether any integrated STD clinics exist.
        - Tom responds that this is a good idea, and there is some work in progress exploring sites to have free lab work in exchange for doing testing.
            - Hilary provides additional logistical difficulties, including:
                - PCPs do not carry/follow protocol to treat syphilis, resulting in the need to make multiple phone calls from DIS.
                - Complication over making patients having to make multiple visits (PCP, pharmacy, back to PCP, etc.) that could have all been resolved with a STD clinic. (3 or 4 visits over 3-4 weeks instead of a one-time visit.)
                - A lot of labor and not really achieving results. Having to connect with other agencies.
                - Everyone having insurance in MA is a myth. Still a significant population without insurance.
            - Stu mentions that this situation can teach lessons for other parts of country. Stu believes it would be important to document this problem of trying to work around the insurance issue.

- MA treatment guideline is higher than the national guideline (double the dose) for syphilis in order to avoid resistance.
- 15-19 and 20-24 y.o. groups have the highest # of cases among CT and GC.
    - Points to the need for health promotion/awareness and education – MA DPH Websites:.
        - STD411
        - Get Tested Boston
        - Etc.
        - These initiatives are getting good usage.

2. CONNECTICUT STATE REPORT: HEIDI JENKINS

- GC cases disproportionate among blacks in the state of CT.
- 2008 saw 2,900 cases of GC reported. A significant increase.
- More females than males have been reported with GC.
- 15-19 & 20-24 constitute the majority of the cases.
- African-Americans saw increases, while whites and Hispanics have remained relatively at similar levels (i.e. stable, no change).
- Hartford, Bridgeport, New Haven signify some of the poorest counties in the country; this is contrasted to the significantly wealthier counties near the border to NY state.

- GC by provider type: private provider and hospitals consist 50% of the cases.
- 5 DIS and 2 supervisors
    - Although 300% increase was seen in syphilis reporting, CT has lost substantial funding for syphilis elimination (perhaps due to initial success in the work done).
    - "DIS Priority Assignments 2009" – document created to identify priorities
        - Not having much success with syphilis right now.
        - Only 1 clinic targeting MSM population specifically.
        - At a complete loss with what to do with syphilis. A lack of community involvement.
        - Trying to focus on where to get the most effective interviews (less than 25 y.o. category).
        - Strive to interview re-infections and co-infections.
- School-based theater presentation on STD, HIV, and pregnancy prevention to engage the students.
    - Following presentation, there is a screening and sexual history to determine whether need for testing for GC, CT, and syphilis is required.
        - Shown to have 10-15% CT positivity and about 3 cases of GC on any given day.
        - Speaks about doing outreach into the community to do screening rather than merely STD clinics.

- About a 25% re-infection rate for CT and GC re-screen based on DIS numbers. Believes that majority of the re-infected consists of CT.
- A little bit of phone interviews has been done, but no significant major movement on this aspect.
    - Hartford's school-based health center has some phone-based interviewing taking place. Shown to be successful while preserving the student's anonymity.
- "Pull tabs" outreach to adult bookstores seem to have been utilized by users (particularly MSM population). Looking to expand this in the summer.

3. BREAK-OUT DISCUSSIONS

Priority populations for state

CT
- African-American
- 20-24 y.o.

ME
- African-American
- Around the Portland area
- 15-29 y.o.

NH
- African-American
- Particularly in Manchester, the largest city among the low morbidity state.
    - Geographic clustering

VT
- All cases throughout the state, all ages, all sexes
- Geographic distribution: Rotland, Rattleborough counties, across the map
- Have the time, and can invest in interviewing all cases
- Particularly Burlington, but would be interested in breaking Burlington into Census tracts and see where the clusters are.
    - Breaking into areas with <= 3 and confidentially analyze for geographic clustering.

RI
- City of Providence
- African-Americans
    - Further analysis on age, sex, partner information from STDMIS
- With new DIS coming onboard, become more involved in the process. Work with nurse, weekly meetings to make sure that cases are assigned and taken care of.
    - Ensure a targeted DIS effort.

MA
- Boston and Springfield
- GIS mapping with Boston and have better targeting approach
- 15-29 non-whites
- Conduct match with HIV registry to determine if MSM is indeed in need of attention.
- Collection of information by school for information on students
    - But students do not all live in the same area
- Zip code analysis

Screening: Assess GC screening coverage of at-risk populations?
Recognize that not all states have high or moderate or even just morbidity areas.

CT
- Difficult to determine
- Can get screening data from the screen lab, by site, by provider, by positivity.
- Will collaborate with Mike in RI to see how MIS can be used and how to use.

- Target the 3 largest cities and the larger providers within the cities to discuss screening coverage.
- But this data is difficult to obtain
    - ER is a popular source for people to go to, but it's difficult to go into the ER and conduct provider interviews about GC. ERs are tough.
    - There are some ongoing relationships with primary care providers and community health centers.

ME

- Also agrees that it may be difficult
- Can get total number by site from the lab to get overall disease
    - But with private labs, will need to talk to them about getting # of GC specimen.
    - The lab will also include numbers for CT and syphilis.
- Private providers in key areas: Portland
    - Also interest in rural area-based providers and getting them onboard to conduct regular screenings
    - Regardless of positivity, would be interested in just improving screening overall in the state.
        - "Who's not, but should" (be doing screening).

- Isolating the denominator (e.g. African-American females 15-29 in City X under care of provider Y) is difficult.
    - Identifying key providers for GC.

NH

- Look at where people are testing positive, clinic-specific and location
    - Work with those area providers, and ask about their screening.
    - Providers may not be aware of epi, so would help them understand and increase screening

VT

- Able to get a denominator for the state
    - But there are an additional 3-4 private labs that look at screening
    - May be more complicated than necessary to aggregate all data.
- Take on a more targeted approach with already available data to conduct analysis
    - Then broaden to include providers in the area based on this data
    - Publish a friendly report via the infectious disease bulletin to inform and create awareness in private providers.
        - In doing so, also bring private providers onboard to connect them with STD resources available.

RI

- Provide data to FP and STD clinic sites.
- South Providence is a key area for people who need to be screened but are not screened.
- Given that males are not seeking regular care via PCP and resort to using STD clinics when symptoms present, target the area and the providers there.
- Females are diagnosed in FP sites, but females might be using other sites/facilities without being tested.
    - Males may be accessing other sites and not being screened .

MA
- Will try to tap the HEDIS measure for not only CT but also GC data
- Include a question on the BRFSS youth survey to find out if youth have been tested for STDs, and including a time bound on the question (e.g. In the last 6 months…)
- Ensure HIV/STD screen sites across the state are doing a good job of screening the target population within the area.
- School-based health centers conducting combo test in Boston area, and consider the possibility of expanding to Springfield.

Opportunities to expand screening coverage of at-risk populations

MA
- Tap into HIV partners to see if they have any stand-alone HIV testing sites, many of which should be expanding.
    - Try to convince/encourage these HIV testing sites to also conduct STD testing.
    - At the HIV sites (Integrated HIV testing sites), CT at 6%, GC at < 1%.

NH
- HIV money has 2 arms: prevention & clinical services (HIV counseling, testing, and STD screening and treatment). Stipulate that contract bids are inclusive of both HIV and STD screening and treatment (as part of the new HIV prevention grant).

Assess adequacy of access to care and treatment of individuals with symptomatic GC

RI
- 2007 and 2008 revised form to include checkbox for symptomatic and asymptomatic.
    - 60% of the time filled out, but able to use MIS to filter out where symptomatic and asymptomatic people go and determine where they go.

Opportunities and next steps to improve and expand access to care and treatment of those with symptomatic GC

MA
- All health departments should have functional websites at a minimum baseline.
- Help direct individuals to the services they need, hours, etc.

Assess adequacy of partner services

CT
- Not doing well with interviewing GC cases, especially in the largest cities
- But this is more DIS-specific
- Looking into Cefixime, but would need a statute before implementing.
- Has a form with checkable option to indicate how the partner's screening and treatment would be taken care of.

MA
- Cefixime and its potential to treat people (partners) rapidly is a good sign.

ME
- Thinks this is a difficult task to make assessment of this

- FP sites do CT partner services, but not GC
    - So this brings up the question of how to bring in the GC notification aspect, especially among the private providers.
    - Since all cases are followed-up, need to determine how to conduct the follow-up after the initial screening activity performed by private providers.
    - But first need to find out and identify private providers and whether they're doing screening.

Opportunities/Next steps to improve and expand access

- Direct DIS to high morbidity areas
- Reaching partners via the available options and mechanisms
    - Doing something for the partners is better than doing nothing

Community engagement relevant to implementation and improvement of enhanced

MA
- Having website to provide information and promote messages

VT
- From the data/epi, sometimes forced to be more reactive than pro-active.
    - Example: responding to Planned Parenthood that popped up with cases, which ultimately led to some discussion, education, and partnership resulting in screening activities and connection to the provider.
    - Resulting in provider initiating the screening process.
    - Parallel process that leads to having a way in/entry.
- Look at where the numbers are, and see if there are any local organizations or community leaders who are probably already aware of what's going on in their community. And then try to reach out to these groups or community leaders.

MA
- Community colleges are easy picks to reach out to.

CT
- Community college is also a good choice, and often times end up detecting CT there.

JSI
- Will talk to Minority Health group per Kathy's recommendation

- Existing infrastructure that can be plugged in.
- National aggregated organizations that have local chapters to engage.

Summarize your plans to enhance GC prevention efforts over the next 3-6 months?

(Handout collected)

4. CLOSING COMMENTS FROM STD DIRECTORS

- Heidi says she would like to devote more energy and attention to this. The discussion was helpful and useful to her.
- Jennah was a little hesitant initially, but this has turned out to be interesting for her not only for GC but also for many other aspects. Think a little differently about program priorities are, and how to decide what the other things that lie outside the normal things that she needs to address.
    - The initial approach during planning felt a little exclusive, as she did not feel like she was included in it. Her state is a low morbidity/incidence, so the expectations are different for low morbidity state vs. moderate to high morbidity states. So some advance communication this expectation would have been very helpful for her.
    - Kevin's response is that Region I is a low morbidity area overall, and will take comment into for the next planning.
- Robert says this is very helpful. The syphilis problem is also shared. There are some simple things that can be done to increase awareness, but has been brought to the forefront once again to work on. Previously with staff turnover and low staff, this aspect got overlooked.
    - The same low morbidity issue Jennah mentioned is also shared.
- Daniel acknowledges that GC is not infectious syphilis and also not CT. GC has the potential to inform other operations, e.g. cluster interviewing process can be borrowed from syphilis to apply to GC.
    - Especially in light of the health disparities, this is very useful information although Vermont has low morbidity. But he was able to pick up a lot of information from other higher morbidity states and looks to exchange ideas.
- Mike also had reservations prior to coming to the meeting. Generated good ideas and thoughts and shared knowledge about Epi info, MIS with others. Also learned something about DIS work. With new STD person coming onboard, will be able to share knowledge.
- Hilary finds that the examples and discussions to be very helpful, the exchange of information is helpful for her.
    - Partner services is of particular interest to her. GC has not been treated as a priority on a broad level, but from a smaller scope (e.g. perspective of a town), there is useful information.
- Tom acknowledges that MA is barely surviving and on the verge of having to contract out some of the work. Hearing what other states are doing is energizing to him. Northern states like Vermont actually have more information on GC than MA.
    - But prevention and condoms were not included as a substantial part of this discussion. While we focus on screening and treatment, comprehensive sex education should be on the radar again.
    - Kevin mentions that the prevention element is not lost on his or Stu and understands that there is a behavioral component.
    - Learned much about GC and will be able to apply to other aspects of his program.
- Mike asks about what the long term outlook is like.
    - Kevin realizes the need for money, TA, etc., and this is an intermediate step for what's to come. And will continue to re-defining and shaping the plans for the future and resolve the systems issue.
- Kathy acknowledges that there is no clear guidance on screening for GC as for CT. Points to the need for a central message about GC and asks the CDC to take the lead on this work.
    - Kevin mentions that there are also opportunities at the local level to be provide a clear message of communication, and he points to the example of Daniel's infectious disease bulletin.

- Kathy identifies the lack of resources is an issue that has been continually raised, as it has been echoed by several people.

Thank you to everyone who participated.