Region I IPP Advisory Board Meeting – November 12, 2009

A. WELCOME AND INTRODUCTIONS

CDC and Guests
- Steve Shapiro
- Charlotte Kent
- Kathy Desilets

JSI
- Jennifer Kawatu
- Kim Watson
- Fong Lui
- Michael Chen
- Jaya Mathur

Connecticut
- Gary Budnick
- Heidi Jenkins
- Angela Cumberbatch
- Susan Lane

Massachusetts
- Jenny Lusk Yablick Sheehan
- Arthur Kazianis
- Tom Bertrand
- Linda Han
- Lynda Sampson
- Hillary Johnson
- Laura Smock
- Roberta Moss
- Patti Parker

Maine
- Jennah Godo

New Hampshire
- Michelle Ricco
- Jennifer Stearns
- Lindsay Pierce
- Carol Loring
- Denise Rondeau

Rhode Island
- Robert Ireland
- Michael Gosciminski

Vermont
- Rebecca Levasseur
- Eunice Froeliger
- Daniel Daltry

B. CDC UPDATE (STEVE SHAPIRO, CDC)

Budget and Funding
- Flat funded at 27.6 million for 2009
- Slight increase requested in the budget for 2010 – do not yet know if that will come through

CDC
- New director: Thomas Freidan, from the NY Health Department
  - Eliminated coordinating centers, reducing some levels of bureaucracy
  - Focusing on 5 broad organizational changes
    - Strengthening surveillance, epidemiology, and lab services
    - Strengthening support for state and local health depts.
    - Strengthening global health work
    - Improving policy effectiveness – using current/future statutes/laws to affect public health policy; he helped push through trans fat ban and tobacco control in NYC
    - CDC to address health reform
  - He is interested in increasing use of data – interested in the data that CDC branches have to share
  - He has been developing public health grand rounds re: auto accidents and hospital acquired infections; will probably be one on STDs in several months

DSTDP Update
- Chlamydia Immunology Consultation
  - Special edition of public health reports – will print publication when finalized

- STD Lab Guidelines
  - Hope to publish them in January or February 2010, though relatively finalized
  - For laboratorians
  - Urine not specimen of choice for women
  - Urine is specimen of choice for men, as opposed to urethral swab
  - Alternate specimen collection also addressed (rectal and pharyngeal)
  - Repeat testing (i.e. repeat running of a specimen in lab) for CT no longer recommended
  - Repeat testing for GC in lab recommended only under certain circumstances
- STD Treatment Guidelines
  - Recommended regimen for even uncomplicated gonorrhea will change from 175 grams to 250 grams (going back to guideline had in 2006) in order to try to delay antibiotic resistance.
- Community Health Center Consultation
  - Trying to figure out how to create partnerships with other organizations to screen everyone necessary – community health centers are a natural partner
  - CHCs and STD programs sometimes speak different languages – will have to learn how to talk with each other before implementing programmatic changes
  - Advisory board members encouraged to talk to Kim/Jennifer if they identify a CHC that would be a good partner
    - In CHC, leadership is key – e.g. CEO has to decide that test will be provided, after that takes a few months to finalize
    - Advisory board members' experiences with CHCs:
      - Many CHCs not accepting new patients
      - If asked to provide new services, need to be paid for it
      - Interesting data comes out of CHCs, especially when serving underserved populations, e.g. refugees
      - Some CHCs don't want to deal with another lab
- PCSI
  - PCSI starting health disparities work, new terminology: "differences in health equity"
  - Denise Rondeau, NH: states it would be helpful for CDC to increase communication with health officers in the states – as sometimes disconnect seems evident.
- Program Evaluation and Program Improvement
  - Trying to improve this at the community level
  - Exploring using continuous quality improvement; traditionally done in clinical settings, but there is an RWJ initiative to see if it can be applied to public health settings, e.g. STD program activities
  - Trying to document best practices/promising practices; could then be used as part of continuous quality improvement initiative
  - Just beginning this initiative
- Erythromycin Ointment Shortage
  - Hoping this would fade by beginning of Nov., but unclear if it has (see CDC website for up to date info)
- Ceph-R Gonorrhea Consultation
  - Meeting held in September
  - GC is especially important because of the resistance factor
  - Containment isn't an option, because we probably won't know it's there until after there is a treatment failure
  - Physicians often won't realize the treatment failure because if there is a treatment failure, the patient may go to different provider
- STD Awareness Campaign GYT 2009
  - 275,000 unique visitors to website
  - Planned parenthood affiliates
    - Increased screening (targeted, refer to slides)

        - Preliminary results (refer to slides)
        - Final PPFA report
        - Separate CDC reports in late 2009
        - Partner meeting
    - Tom Bertrand, MA: feels HIV testing may not be the best use of this money in young women and hopes that STD screening is incorporated into HIV testing efforts if HIV is integrated into STD awareness month.
- IPP Activities
    - PTO initiatives
    - Behavioral risk data
    - EPT – hearing about implementation issues; even those providers willing to use EPT complain that they can't bill for service; have people been hearing that in this region?
        - AMA doesn't have a code for that (for billing purposes)
        - In MA, wrestling with issue of writing one prescription for patient/partners or separate prescriptions
    - HRSA 340B
        - Appropriate use of Access
        - Presentation from military at Coordinator's meeting:
        - There are five branches of the military with completely separate policies re: screening
        - Need to be screened if recruits, but army doesn't until after 6 months
        - 30,000 women may go unscreened
        - There is a website that publishes military morbidity

<u>National Chlamydia Coalition</u>

- Why do we talk about gonorrhea?
    - There was a decrease in GC morbidity in the 70s, but have since plateaued
- GC concentrated in:
    - South and Midwest of the country
    - Minority populations in urban areas
- Differences in health equity in 2008 – 19 to 1, African Americans were more likely to have GC than White Americans
- Resistance to cephalosporins
- May require use of IV antibiotics in future
    - Will affect clinic flow when this resistance happens
    - No indication that there will be a problem with injectables, but there is an indication that there will be a problem with orals
- Emergence of gonococcal antimicrobial resistance in the US

<u>Regional Gonorrhea Meetings</u>

- Went well
- Develop action plans
- Identify priority populations

<u>2010 CSPS-IPP Applications</u>

- Dual test is not an appropriate action plan for gonorrhea, because the dual test is generally based on Chlamydia morbidity, i.e. does not target gonorrhea
- Note regarding GC screening: If data show that don't have core area to target, can go outside of the core area to target, but have to prove it in application (e.g. Maine) Use data to support decisions.

C. COORDINATOR/NCSD MEETING REVIEW

Coordinators Update

- Interested in exploring collaborations with other partners, e.g. Society for Adolescent Medicine
- Advisory board members should also think of people doing STD research, who would be interested in creating partnerships

NCSD

- In the process of hiring new technical director – will hopefully be announced on January 1st
- Last week had annual meeting

D. CHARLOTTE KENT PRESENTATION

Background

- Jennifer: Invited Dr. Kent to talk about this because there have been a lot of questions and no clear guidance regarding male testing; so it would be great to get the evidence from CDC
- Dr. Kent has been at CDC for 2 years
- Passed out supplement developed for consultation

Intro to Epidemiology

- 3x higher reported cases in women than men; women may carry infection for longer
- Asymptomatic in men as in women, so probably a lot of undiagnosed infection in men
- SF prevalence almost same in men and women; have done a lot of targeted screening of men in SF
- Age distribution
  - Peak prevalence in men: 20-24
  - Peak prevalence in women: 15-19, drops a little in 20-24
  - Higher in men 20-24 probably because of sexual partnering patterns (men often a little older than female partners)
- Race/ethnicity
  - Prevalence is higher amongst blacks both men and women, even more so men.
- Population data on male CT – Catherine Satterwhite
  - AddHealth used as data source
  - National job training program, i.e. job corps – very high prevalence of infection
  - MSM prevalence monitoring project – high prevalence, but also symptomatic men seeking services so could explain it
  - Chlamydia trachomatis positivity rates among men tested in selected venues in the US: a review of the recent literature
    - Prevalence much higher in southeast than in west, so recommendation to look at which settings are appropriate in your geographic area to capture CT positives
    - If it works in one place, may not work in another
  - CT – positivity by age group and sex, adult corrections facilities
    - 18-19, females, positives 18%
    - 20-24, men, positives 8%
    - Some facilities do screening at intake, others do screening after several weeks
    - This represents about 40,000 tests
  - CT prevalence among females and males in youth and adult detention by age group: SF
    - Screened 50% of people in adult facilities (because of money issues) in SF
    - A lot more people in jails than juvenile facilities
    - Infection rates similar for adults and youth in detention facilities
    - Strong recommendations for females in juvenile facilities,– should have some more recommendations for that population

        - Prevalence twice as high in 18-25 in jail than in 12-17 in juvenile facilities
        - Can detect 4x as many infections in jails than juvenile facilities
    - Reported CT among males by provider type: NYC
        - 2004 data before screening men in jails, compared with 2005 after they started screening men in jails
        - A lot of the infections in STD clinics probably symptomatic
        - When started screening all men in jails, not just symptomatic, # rose from 222 to 3854
        - Because GC tends to be more symptomatic than CT, don't see quite the same pattern – more infections in STD clinics than in jails
    - Impact of jail screening on community Chlamydia rates: SF
        - Chlamydia in women infection focused in southeastern part of city
        - Same neighborhoods with high ct rates are ones with high incarceration rates; probably why see so much infection in jails
        - Family planning clinic O v. clinic S (clinic O in low prevalence community, clinic S in high)
            - Prevalence 4x higher initially in clinic S, but 50% drop in infection in clinic S after jail screening criteria changed
    - Rate and predictors of repeat CT infection among men
        - Men 15-35 yrs with CT from Baltimore, Denver and SF
        - Repeat infection rate was 13% in men (similar to women)
- Cost-effectiveness analysis of screening men for Chlamydia to prevent pelvic inflammatory disease in women
    - Where should the dollars be focused?
    - Modeling male CT screening
        - Societal perspective costs – in public health, often try to think about this perspective (i.e. not health care perspective)
    - Most of data from CDC funded study; two sexual activity groups (high and low) based on two papers
    - QALYs
        - Try to create a measure to compare health outcomes
    - Provides comparison between screening men vs. expanding screening to more women.
        - Based on study data, screening men becomes more effective and less costly than expanded screening of women at twice the positivity of women in the same population sample (i.e. Reference point is the same population in both scenarios; refer to graph)
    - Findings:
        - Screening men a viable program alternative to expanding screening of women; dependent on:
            - Men available for screening being high risk
            - Women available for screening being at less risk
        - Benefit of screening men leads to helping to reduce infection to women
    - Kathy Desilets raises the issue of whether this study is applicable to Region I, esp. considering the relatively low prevalence rates. This is something that Charlotte acknowledges and agrees with – screening men should not displace screening of women in high risk groups
    - Kathy asks a separate question about the short transition time between jails. Given such short time, how is screening and treatment managed?
        - Charlotte provides some clarification and specific examples (San Francisco, Philadelphia, Los Angeles) about how these cities handle screening and treatment
    - Steve mentions that it is important to look at how services (and thus money) are allocated. Decisions on who to screen and how much to screen should include considerations for data and identification of need
- Male screening can be paid for by up to 10% of IPP dollars

- MA Health Quality partners make recommendations on development of guidelines. Also provides screening services for males and females less than 25 y.o.
- In National Health Care Reform, routine male screening is likely not to be covered. Only cover USPTF A & B recommendations
- United Kingdom does cover male screening
  - Do less screening of males than females, but nonetheless a covered benefit

- Male Ct Screening Consultation Summary – Meeting Report
  - Did not consider any recommendations on whether programs should adopt or expand male CT screening programs
  - To help make decisions about which populations of male to screen for CT and how to best approach
  - Priorities include: STD clinics, Job Corps, and < 30 y.o. entering jails
    - Other priorities include re-screening at 3 months, urine specimen and NAATs preferred, partner services, etc.
- GC and CT among MSM, possible impact on HIV transmission: implications for screening
  - In STD clinics in San Francisco, early syphilis 2%; GC 12%. A lot more GC than syphilis
  - CDC released screening and diagnostic testing guidelines for MSM in 2002.
    - But adherence to guideline is low. Reasons:
      - Providers and patients perceive low need for rectal testing
      - Rectal cultures also not readily available
      - STD clinics
      - Most STD clinics do not perform routine rectal CT testing
      - Most gay men's health centers do not perform routine GC/CT rectal screening
      - Reimbursement issues, lab test FDA clearance issues.
    - Higher rectal than urethral for both CT and GC
    - Majority of rectal CT and GC infections are asymptomatic, so unless rectal screening occurs, infections will go undetected
    - Site of infection stay segregated to the specific site of infection – i.e. rectal infection stays rectal infection, likely not to migrate to urethral
    - Rectal screening is important because:
      - HIV seroconversion shows that rectal infection is a tremendous risk factor for HIV. This is a risk marker for HIV infection.
  - Pharyngeal GC study
    - Pharyngeal GC rate highest amongst gay/bi men (4.7%)
    - GC much more common to be detected in pharyngeal than CT. This may be attributable to the organism itself, biologically
  - Tom raises question about increasing numbers for males and females for CT infections. Given challenges with limited resources and need to establish justification for programs to exist, sees compelling value for using data to advocate for STD services. What is contributing to the continual rise of CT infection from 1988-2007?

E. INFRASTRUCTURE PRESENTATION

<u>Positivity</u>

- 2009 Q1 and Q2; as of Q2, 10% down in number of tests; expect to have 50,000 tests, not 55,000 tests; still seeing bringing on new facilities
- Positivity remains at about 4%
- In Q1 and Q2, seeing a few more upticks in positivity

<u>Regional Goals and Objectives</u>

- Objective 1.1
  - Not going to reach this goal; estimating reaching 34,914 for 2009
  - Possible reasons for this:
    - Increase in size of that demographic

        - 3 of states have screening criteria in line with CDC, 3 states are one year younger
        - 2,000 tests done in women over age criteria, who have no risk factors
    - Comment re: dwindling numbers: users of Title X have also been going down. If we keep the same sites, but at the sites, the target pop is dwindling, then numbers for IPP will dwindle as well
- Objective 2.2
    - Some room for growth in screening women with risk factors – see slides

Provider Assessment

- Highlights
    - Screening behavior
    - Knowledge of CDC screening criteria
- Significance - The usefulness of this survey is mostly descriptive because not a lot of significant results with cross tabulations.
- State-specific results - Print-out from Survey Monkey survey available for each state (distributed at meeting)
- Broken out by Site: Q10
    - 10b: depending on screening criteria of state being surveyed, age was either 25 or 26
    - Not much difference between 10b and 10c, except for CHCs
- Broken out by credential: Q10
    - Q0e: a lot of people being screened outside criteria, evidenced by almost 50% of MDs and NPs answering true to this question
- Only 17 people out of 400 surveyed correctly identified CDC screening criteria and stated that their screening practices were the same
- Going into survey, assumed people knew screening criteria but didn't practice accordingly – not necessarily the case, many didn't know actual screening criteria
- Broken out by site: Q1
    - Many more people answered true to 11b than 11a
    - 11a is true screening criteria
    - More people answered to true to 11c than 11a as well
- Broken out by credential: Q1
    - More people answered true to 11b and 11c than 11a
- Broken out by site: Q2
    - Even older women coming in for PTO only may have higher yield, so might make sense do practice 12c
- Jennifer asks if there is anything AB members would like to see us present or a format in which they would like to see data presented?
    - Had proposed doing an educational intervention that would increase provider knowledge and improve screening behavior
    - AB member knowledge doesn't necessarily trickle down to clinic/provider/staff levels
    - Proposed: educational materials dissemination; clinic-specific data reports
    - E-learning course?
- AB members want:
    - Getting/reporting data on over-25/26 by clinic would be helpful
    - Would be good so that clinics could see their progress
    - Would be helpful to have PPT or something with actual criteria to give to providers
    - Would like to see survey repeated with multiple choice instead of true/false; could use it as a training tool, that will give immediate results and show you the correct answer
    - E-learning tool could be good for providers (but is expensive to develop, which is the main barrier); there could possibly be borrowable content from existing tools or room for collaboration on a new tool

Maps

- Hoping to do some geo-coding between the distance a client will go to a clinic for a test and their home; was not able to do this due to missing Zip Codes in data
- A large circle represents higher positivity
- Gray areas are ZCTAs – a census track geographical area
- Note: This region has a fairly large number of screening clinics that are not identifying disease; they may be inactive clinics or clinics with very low positivity
- Steve: everybody should be doing this kind of mapping!
- Kim: some states have better zip code data on patient level; our next step is to get these maps out there for you to look at, zoom in so you can see the detail, and get a sense of what is useful to you; Kim will get in touch with each state about zip code data
- Immediate thoughts about what would be helpful for maps:
  - Tom, from MA: need to do a better job of cleaning up inactive sites; may want to only present sites by volume, but will think it through a bit more; may want to present sites by clinic type in maps
  - Susan: census population age distribution would be helpful (Kim: we could do that, but we won't necessarily be able to see changes over time because data isn't updated annually)
- Next steps
  - Will send maps out to all members
  - Will put the maps on the web site
  - Ask members to take a good look at them and think about what else would be useful
  - Would it be useful to plot lab to gauge travel time for specimen collection?

F. STATE REPORT BACKS

Rhode Island

- State budget is terrible
- Will be losing 8 days of pay between now and end of fiscal year; but will pay in vacation time
- Swine flu is tough – dealing with database
- Have brought on 3 new IPP sites, started Oct 1 – now have to get their data into IPP database

Connecticut

- Have added 3 sites in last year
- Today discussed looking at PTO, especially if could separate CT and GC; would see more tests as a result
- Lost 1 staff member
- Jan/Feb plan to get Chlamydia instrument online, so can upload data
- Have updated lab slip – added address

Massachusetts

- In terms of data, have been talking with FP sites – identified something not user-friendly on lab slips, that will be fixed by Jan 1
- STD clinic funding cut; BMC will do tests for people w/o insurance (cost $85 per visit); decrease in visits as a result
- To compensate have been working with lab to target new sites, e.g. school-based health centers
- Good news from Title X site ABCD, that wants to add Upham's Teen Clinic in Dorchester – expect large volume, at least 400 tests per year
- In MA, last year saw a 75% increase in infectious syphilis cases
- Doing education on partner services – good public health initiative and to reduce re-infection (new brochure out and available)

- Especially would like to target non-primary partners for those infected with multiple partners

New Hampshire

- Have full state staff now – Lab, FP and STD
- Had IPP orientation in October to clarify project details and roles
- From FP perspective, looking at 6 of the 11 FP delegates are in IPP
- Going to create a FP practice protocol based on protocol of highly performing delegates

Vermont

- Lost DIS of 28 years
- Have an intern from UVM, someone around the same age as those being served by IPP
- Started a pilot project on a re-screen initiative, piggybacking on planned parenthood initiative – contacting individuals and encouraging them to get re-screened; feedback so far has been good
- Planned Parenthood still processes specimens, but now Converge does as well
- Working with both agencies to identify seamless dissemination of results
- Will work on an education dissemination piece re: provider assessment and screening criteria
- Hoping to stay under 50 for GC
- BCBS has majority of providers in state in the system, will send letter to providers re: importance of CT screening in target populations; tailored it to a VT perspective

Maine

- STD program down 2 staff, one of which was long-time DIS; position can't be filled for 2 years
- Trying to get new people in
- EPT – legislation in the works, passed unanimously in the House, now going to Senate; looks like this Spring it could be in place
- Texting pilot with FPAM as a screening reminder – initially language and confidentiality (HIPAA) was a barrier, in revisions; hope to have better report of this in June

G. COMBINED SCREENING & TREATMENT AND DATA SUBCOMMITTEE MEETING

- Is there a way to come up with unique IDs for CT patients to track re-screening?
  - Each state does not have an identifier to run their own reports
  - Would have to put in the practice management system who was positive, which they didn't want to do (re: confidentiality?)
  - In VT, have unique client number within each lab, but no way to get labs to speak to each other (i.e. labs outside IPP network); is there an easier way to code this?
  - Who should spend the time doing this?
  - Requires creating a new field
  - How close would you come to have a unique identifier if combined date of birth and zip code?
  - If we are going to prioritize re-screening as a measure, then will take away initial screening (because have a limited number of tests)
  - If had a repeat offender, would do more outreach re: partner services with them (MA)
  - The goal is to see people re-testing positive come out negative, but won't know that from current data
  - The goal of the re-screen is not just to promote partner services, but because they have a higher likelihood of CT and sequelae such as infertility
  - Region VIII has a unique identifier – data entry is done at the lab, last name is coded with DOB as unique ID
  - Lab slips could have a number – but not unique to the patient, unique to the test

- Complex codes have been pursued for HIV – usually the onus is on the provider, not automatically generated, e.g. DOB, first 3 letters of first name, first 3 letters of last name, SSN
- Patient number plus site number?
- Steve: other regions are discussing this same issue; Region 9 is a little further along; issue comes down to resources – where are you going to get the resources to re-screen v. initial screen? Bigger bang for your buck on re-screens than initial screen for 27 year old (need to look at state-level data to see if it supports this). Generally re-screened population positivity higher than first screen (especially of older women)
- Is it feasible to manually put positives in the system? Could do this list monthly or every few weeks, and keep the results on file
- Consensus of the group: local issue for each state, not going to come to regional consensus
- Steve: is there commitment to do it for all states in the region? Or can states opt out?
- For ME, not going to commit to finding new way of doing unique identifier, currently do chart review and it works
- For MA, annual site review
- For NH, probably not doing anything, but something considering doing when doing site visits
- This is a priority, but maybe not a top priority for all programs

- How are IPP sites selected?
  - How is everybody integrating requirement to keep sites at 3% or higher?
  - In MA, going to look at data for first 6 months of the year – if not above that, site will either be dropped or needs to come back with a plan to improve and be improved at the end for another 6 months
  - In ME, a handful below 3% - if those sites remain that way (were given a year notice), they will be dropped
  - Michelle: Anyone looking at how to incorporate sites with more target pops? Need to put more resources into areas where there is a higher threshold?
  - In NH, will reevaluate where currently putting funding; have been funding many sites for many years, so need to re-assess; positivity rates will be part of formula
  - In VT, continuing to monitor positivity; funding goes to PPNNE, and money distributed equally to all 14 PP sites; even some sites that have patients mostly coming for ob/gyn services
  - Steve: if data suggests 40% of money should go to FP, then should do that, even though 50% is the recommendation
  - In CT, evaluated IPP sites based on positivity; have to prove positivity before can add more sites
  - In RI, took out site less than 3%, offered inclusion to remaining Title X sites in state, some declined, the rest were brought on board; based on a formula how many people they see in each age group

- Risk Factor Data – preserve or update risk factor data being collected; analysis
  - MA, always wanted regression analysis of existing data, to see what risk factors were predictors of positivity (project for intern or Jaya?) – at least for over 25/26, but all ages if possible
  - Susan: would like to be able to say, you think this is a risk factor, but it's not

- Provider assessment next steps – see main meeting minutes

- Agenda items for next meeting (June), additional topics to be discussed
  - Follow-up of risk factor analysis
  - GC screening efforts (get updates from states)

- Report back on state efforts re: re-screening
- Update on prevalence monitoring for each site (re: 3% positivity)
- Review of regional objectives
- To complement GIS mapping projections re: target populations (are they moving to different places? Any other shifts? Racial/ethnic minorities?), any observable trend specifically age, race ethnicity (compare two points in time)

- Facilitators of Subcommittee
  - Jennah Godo and Evelyn Kieltka

H. LAB SUBCOMMITTEE MEETING

Transit time study & Repeat offenders letter

- Continue to be in progress.
- Will be conducting transit time study throughout the whole month of February.
- Jennifer has had to do 3 months, as there wasn't enough data in one month alone (Feb-Apr).
- Gary is interested to see how transit is conducted, whether via courier, rail, etc.
- For those "violators," previous meeting talked about writing and sending a letter. This letter still hasn't been written.
- Bob has one or two in RI, but really just one that's been egregious.
- Jennifer met some resistance from the state, as the state wants involvement in the letter of correction concerning transit time.
  - For Eunice VT and Bob RI, the lab has more autonomy, where the state isn't concerned about how this is handled.
- Gary clarifies that this letter isn't meant to be punitive in nature.
  - Instead, write the letter as a way to reach out to labs and extend an opportunity to work with them.
- Bob proposes to do the study again, see what happens, and find out if it's the same group contributing to the issue; if the same group(s) is habitually late, will reach out to offer assistance to help get lab results back to site in order to proceed with treatment.
- In Jennifer's experience, her 3 months have seen the same sites committing the delay via mail-in samples. Suspects that they're just in holding pattern to stockpile enough specimens to justify shipment costs.
  - Bob recommends to Jennifer to reach out to address this situation, even in spite of the cost of mailing situation.
- Eunice brings up a similar issue with water testing that has seen the postal office address the situation by directing all the specimen to the same processing/distribution center and placing "time sensitive" sticker on the package to expedite delivery.
- At the very least, should work on identifying the root cause(s) of delays in transit time. Find out why exactly transit time delays continue to persist.
  - Shipment cost?
  - Waiting for enough specimen?
- Communicate with Bob via e-mail by early March to identify the labs, so that there will be results by June's IPP meeting (2010).
- Will also work on drafting a letter.

Turnaround time study

- Will conduct this around in May, just prior to the meeting.
- Length: one week, and should be fairly easy to generate.
  - 5/3/2010 - 5/7/2010 (Monday to Friday).
  - From receipt to report

Reproducibility study

- Everyone is within the same ballpark (97-99%).
- Need to put positive CT back on the table, as suggested by Eunice and also based on results from Steve Shapiro's consultation report.
  - Gary and Carol both strive to remove CT positive re-test sometime by the beginning of 2010, based on recommendations in the process of becoming finalized.
  - Gary is aiming for January, while Carol is waiting for final recommendations to be formally released.
- Based on handout provided by Bob, reproducibility is fairly good across the board.
- Handling of indeterminate samples remains unclear.
- The combo test has an equivocal range that involves repeating; otherwise, if it's positive, it's positive. If it's negative, it remains negative otherwise.
- Everyone appears to be waiting until the release of the formal publication.
- All the package inserts don't indicate 100% for reproducibility.
  - Steve Shapiro reminds that it would be necessary to follow the product insert.

<u>Cost of tests throughout region</u>

- Eunice pays a lot more for the reagents per test than the rest of the region, since this cost is largely based on volume. Explains why some states pay more and some pay less.
- Gary mentions about a conversation on regional pricing earlier, but regional pricing is highly unlikely, as not everyone uses the same testing kits.
- Especially given most of the states are seeing decline in volume, the likelihood of seeking regional pricing would become even less likely.

Agenda items for next meeting

- Make a final decision on implementation of repeating on CT positives (to be discussed in June 2010), if/when guidelines are released.
- Transit time studies
- Offenders letter/issue
  - Wording and official documentation.
- Turnaround time study

I. JUNE MEETING DATES

- By vote more people preferred June 14/15
- People will send an email if can't make it, or have preference