Region I IPP
Advisory Board Meeting
November 15, 2010

MEETING NOTES

Attendees

- *Members:* Gary Budnick (CT), Susan Lane (CT), Marcy Moyel (MA), Jenny Lusk Yablick Sheehan (MA), Arthur Kazianis (MA), Christina Lombardo (MA), Roberta Moss (MA), Hillary Johnson (MA), Laura Smock (MA), Lynda Sampson (MA), Jamie Holland (MA), Jennah Godo (ME), Jemelie Bessette (ME), Evelyn Kieltyka (ME), Michelle Ricco (NH), Lindsay Pierce (NH), Carol Loring (NH), Barbara McNeilly (RI), Rebecca Levasseur (VT), Eunice Froeliger (VT), Daniel Daltry (VT)
- *Public Health Representatives & Guests:* Steven Shapiro (CDC), Kathy Desilets (DHHS), Rick Steece (CDC), Linda Niccolai (Yale)
- *JSI:* Jennifer Kawatu, Andee Krasner, Fong Lui, Jaya Mathur

A. Welcome & Introductions (Jennifer Kawatu)
    a. Kim is leaving the IPP project to become a Director of Monitoring & Evaluation for an HIV/AIDS project in Zambia. She will still have same email as she is still with JSI and is available for consultation.
B. CDC Update (Steven Shapiro, National Coordinator, IPP)
    a. CSPS 2011
        i. Technical reviews have been completed, have gone to Procurement & Grants Office
        ii. $1.546 million in additional funds were awarded to CDC in FY 2010, but CDC only recently received the funds
            1. $118K will go to the National CT Coalition
            2. $190K will go back to Infrastructure and compensate for a reduction in funds that was slated to occur
            3. $500K will go to "The Future of IPP" (see more later)
            4. $730K will go to additional project areas, as a supplement to the 2011 funding award
                a. The funds are intended for the expansion of CT/GC screening and treatment services
                b. The percentage of additional funds awarded will match the usual percentage of funds awarded
                c. Project areas will have to submit a 5 page proposal for how they intend to use the money
    b. DSTDP Update
        i. Personnel
            1. The division has been Director-less for a few months
            2. Dr. Charlotte Kent is now Acting Director

3. CDC is hoping to have the new Director confirmed in the next several weeks

ii. Agency is focused on "Winnable Battles" per Dr. Friedman
    1. These include: tobacco control; nutrition, physical activity, obesity and food safety; health care associated infections; motor vehicle injury prevention; teen pregnancy prevention and the ramifications of the Affordable Health Care Act.

iii. Consultations

iv. Guidelines
    1. The CDC 2010 laboratory guidelines should be released soon

v. The new 2010 STD Treatment Guidelines are also expected soon.

vi. The 2009 STD Surveillance Report will be available online next Monday, November 22nd

vii. Hard copies are not being produced this year. Please download instead.

c. Health Care Reform
    i. CDC is asking project areas the ways they are involved in health care reform
        1. Maine
            a. Maine has a new governor
            b. It is not yet clear what direction Maine is going in
        2. New Hampshire
            a. FP is at risk of funding cuts
        3. Vermont
            a. Vermont Department of Health is at the table
            b. Vermont has lost staff position, but is being asked to do the same level of work
            c. Vermont Department of Health is hopefully making some progress on getting CT and GC to be seen as integral to public health
        4. Massachusetts
            a. There are a few evaluation projects happening
            b. There is interest from other states in Massachusetts's experience with Health Care Reform
            c. Massachusetts STD clinic funding has already been drastically reduced
        5. Rhode Island
            a. Rhode Island has a new governor, who is an independent, unsure of direction
        6. Connecticut
            a. Has a democratic governor and democratic control of the House

b. The state is moving toward FP expansion

ii. Key Issues of Concern to IPP
    1. Performance Improvement
        a. IPP already has performance measures
    2. Affordable Care Act
        a. It is unclear how IPP fits into the Affordable Care Act
    3. National HIV/AIDS Strategy
        a. How does IPP fit in?

iii. "The Future of IPP"
    1. The Infrastructures from the 10 regions have been awarded these funds to lead an evaluation (Region VIII Infrastructure is the lead, but all Infrastructure agencies will contribute)
    2. There was an in-depth discussion at Regional Coordinators' Meeting last month
    3. The Regional Coordinators will present their environmental scan by November 2011
    4. The Regional Coordinators will review what other laws could affect IPP in the future
    5. For the next part of the project, the Regional Coordinators will collect information on what each project area is spending their dollars on, who their major partners and providers are, etc.
    6. The most important part of the evaluation will be recommendations to CDC (given the changing health care environment, what IPP should look like in the future)

d. Gonorrhea

i. Gonorrhea Case Rates by Sex, 1999-2009
    1. GC seems to be decreasing among men and women
    2. By race/ethnicity
        a. GC is dropping slightly among African Americans (though the rate is still much higher than other racial categories)
        b. There have been huge increases in GC case rates among American Indians (especially in New Mexico, where the case rate doubled)
        c. GC case rates among Hispanics, Whites, and Asians/Pacific Islanders are stable
    3. By Age Group
        a. GC is decreasing among all age groups
        b. There has been a precipitous drop in GC case rates among 15-19 year olds from 2007 to 2009

ii. Gonorrhea May Be Decreasing

1. NHANES
    a. The numbers are too small to really tell
    b. Testing was discontinued in 2009
2. Why the decrease?
    a. The decrease is possibly due to targeted screening efforts
3. BUT…
    a. GC cases in Region I (and elsewhere) have largely gone up
        i. ME up 18%
        ii. MA up 20%
        iii. NH up 47%
        iv. VT up 24%
        v. CT down 3%
        vi. RI down 11%
    b. Increases in GC case rates generally occur in areas where antibiotic resistant GC first show up
    c. The Gonoccocal Isolate Surveillance System sends in cultures monthly, tests antibiotic resistance, and issues new alerts
    d. Chicago is no longer using oral cephalosporines, only injectables
    e. Maine and New Hampshire are seeing more cases of GC among heterosexual women
    f. Vermont has many GC cases among older men, which is new; 40% of morbidity is from out of state and imported, and there is a high co-infection of HIV
    g. Massachusetts has GC cases primarily among the following populations: urban areas; Hispanics and African Americans; men 40-49

e. 2010 STD Treatment Guidelines
    i. The final language of the guidelines is pending
    ii. There are no changes to the treatment of CT
    iii. There have been changes to the treatment of GC
        1. Ceficime or Ceftriaxone **PLUS** Azithromycin or Doxycycline as dual therapy – not as presumptive therapy for CT (i.e. dual regardless of whether CT is ruled out)
    iv. Screening among pregnant women for CT and GC – the retesting language has been clarified and strengthened for high risk patients
    v. Screening among young women for CT
        1. The age cutoff remains the same
        2. The new guidelines address the USPSTF age change

3. There has been no change or added clarity to the risk factors
4. There has been new language added indicating that "targeted chlamydia screening in men should only be considered when resources permit and do not hinder chlamydia screening efforts in women"

vi. Screening among young women for GC – there is no change in risk factors, but there is a new emphasis on targeted screening and the use of local data
vii. Screening among men for CT – the language was expanded to allow for venue-based screening
viii. Retesting of CT and GC among women and men – the language has been strengthened

C. Lab Update (Rick Steece)
   a. A presentation of the changes to the Treatment guidelines recently occurred and is now available online (JSI will post it on the IPP web site)
   b. The laboratory guidelines are almost final.

D. Behavioral and Molecular Epidemiology of Repeat Infections (Linda Niccolai, PhD Yale University)
   a. Public Health Importance of Chlamydia
      i. The most common reportable disease in the US
      ii. Over 1 million cases of CT are reported per year
      iii. CT rates continue to rise every year, which could be attributed to greater detection, use of more sensitive tests, etc.
      iv. The true reason for the rise in CT incidence is unknown
      v. CT positivity (i.e. prevalence) is level, if slightly increasing
      vi. Region I has a low positivity rate
      vii. In some regions positivity has been increasing, possibly due to more sensitive tests but also possibly due to an actual CT increase
      viii. There are many deleterious health effects of CT, especially if left untreated
      ix. The highest case rates of CT are among young women, partly because they are tested more often than men
   b. Repeat CT Infections
      i. Repeat CT infections are common
      ii. There was a meta-analysis (of 38 studies) recently conducted in which the median percentage of women re-infected within 6 months was about 14%
      iii. Repeat infections are more closely linked to adverse health outcomes (it is a multiplicative risk)
      iv. People who have repeat infections may be "core transmitters", i.e. responsible for greater transmission within the community
      v. The rate of repeat infections may be increasing

vi. One researcher proposed an "altered immunity hypothesis," which posits that earlier screening of CT prevents women's natural bodily response from developing antibodies to fight off future infections (though this has not been proven)

c. Sources of Repeat Infections
    i. There are three primary sources of repeat infections (assuming treatment failure hasn't occurred)
        1. An inadequately treated partner
        2. An adequately treated but non-monogamous partner
        3. A different partner (than the initial infection)
    ii. Previous research
        1. It is often reported that inadequate partner treatment is the major source of repeat infection
        2. Past research has prompted expedited partner therapy (EPT) as the focus of prevention of repeat infections
        3. It has not been empirically evaluated what proportion of repeat infections are due to inadequate partner treatment
    iii. Behavioral and Molecular Epidemiology of Repeat Infections Study (conducted by Linda Niccolai and colleagues)
        1. Research question: can we empirically quantify sources of repeat infection?
        2. The aim was to determine sources and predictors of repeat Chlamydia infections
        3. The researchers hypothesized that repeat infections might be more equally distributed among range of sources
        4. Data collection was conducted among women age 15 or older with CT via two methods (interview and specimen collection)
        5. Genotyping was conducted, telling researchers whether an individual was re-infected from the same partner or a new partner (i.e. in the former, the genotype would be the same at initial and re-infection; if the genotype were different it indicates infection from another partner)
        6. Analysis
            a. The researchers conducted a logistic regression of relative risk
            b. They looked at the frequencies of untreated, new, and non-monogamous partners at follow-up
            c. They also estimated population attributable risk percents
                i. This measure estimates a risk difference
                ii. This measure is the proportion of disease attributable to different exposures
        7. Results

    a. Follow-up was conducted 4 months after initial infection
    b. 21% had resumed sex with an untreated partner
    c. 37% had a new partner
    d. 33% had a non-monogamous partner
    e. Women were much more likely to have a new partner or a partner that they were not sure is monogamous
    f. Younger women and untreated sex partners are significant risk factors
    g. 26% of all repeat infections are due to continued sex with an untreated partner
    h. 21% of repeat infections are due to a new sex partner
    i. The researchers couldn't estimate the percentage of repeat infections due to non-monogamous partners
    j. Only 8 girls had baseline and follow-up genotypes
        i. 5 of 8 had different genotypes from initial to repeat infection (i.e. were not re-infected from an untreated partner; none of these cases were mixed infections either)
8. Implications for EPT and Prevention
    a. EPT is great for treating the initial partner(s), but it is not completely effective because does not treat other future partners
    b. Condoms are a realistic option to target other sources of repeat infection
9. Implications for Retesting
    a. Retesting remains an important public health priority
    b. Retesting rates remain low in many settings
10. Future Work
    a. The researchers would like to confirm their initial findings with a larger sample size, different populations, etc.
    b. This issue can in the future be addressed with intervention studies, public health, and clinical practice
11. There is an article written using data from this study on girls' intentions regarding getting their partners treated; 70% said they'll get their partners treated and the rest say they're not going to have sex with them again, not my problem, we don't talk about those things, etc.

12. There was a recent article from San Francisco evaluating re-infection rates post-EPT indicating less of an impact than expected of EPT and these findings could help explain that
13. The NIH is currently conducting a study following up with partners to see if they followed up with treatment

E. Infrastructure Update
   a. Ongoing Projects
      i. Lab Slip Changes
         1. The lab slip changes were discussed in June, which are currently being finalized
         2. The new lab slips will be printed in December and disseminated in January
      ii. GIS Mapping
         1. The maps were developed last year
         2. Infrastructure is currently updating the maps from 2008 to 2009 data, and are mostly done
         3. The new maps should be posted in the next few months
         4. Infrastructure explored developing dynamic maps (zooming in, etc.), but in the end it was determined they will not be posted that way
         5. Members should let JSI know if they would like to see particular data in map form
      iii. New Member Orientation
         1. Infrastructure made substantial changes based on the Advisory Board's feedback at the June meeting
         2. The presentation is close to being posted
      iv. PTO Profile and AI/AN Profile
         1. The PTO profile is close to being done
         2. The AI/AN profile is in progress
      v. Project Area Info regarding "The Future of IPP"
         1. JSI will soon be soliciting information from project areas to conduct its evaluation of the future of IPP
      vi. Provider Materials
         1. The provider materials have been printed and will be disseminated in the next few weeks
   b. Screening Criteria in Project Areas
      i. Risk Definition is STI in past 12 months
      ii. Data Collected is "STD contact in past 60 days" which is not consistent with risk definition
      iii. Risk Definition by CDC and USPSTF – not specific
      iv. Next Steps: Options
         1. Redefine the STD field to mean "STD in previous 12 months"

2. Keep “STD contact in past 60 days” and add “STD in previous 12 months”
3. Thoughts?
    a. “STD” on the lab slip could mean many different things (in the code book the definition is “60 days”, but it could be interpreted differently)
    b. It makes sense from a data perspective to add “12 months”, because the lab slip should reflect eligibility
    c. Do we have a lot of cases with “60 days” checked and no other risk factors? No
    d. It would be nice not to add a new variable
    e. The clearer the variable definition is on the lab slip itself, the better

v. Adoption of New Variables
    1. Infrastructure has compiled a chart listing the Region I states and the variables each will be adopting
    2. Infrastructure would like all lab slip changes submitted by the end of November

vi. Definitions of New Variables
    1. The definitions will not be on the lab slips, but will factor in to how providers are trained to use the lab slips
    2. PTO – Infrastructure will leave “no physical exam conducted” in the definition
    3. Re-screening – Infrastructure will edit language to say “not an annual exam”
    4. Other – as option for gender. According to Steven Shapiro, if there is no risk of infertility, IPP dollars should not be used for testing

vii. Next Steps

viii. Facility Positivity
    1. CSPS requires complete IPP facility positivity, but Region I has been collecting just IPP positivity for each facility
    2. Project areas should initiate conversations with their sites regarding collecting non-IPP positivity data in addition to IPP positivity data
    3. Infrastructure will work to collect this data from state and private labs

ix. Overall Testing Data
    1. National testing rates are rising, but in Region I testing is decreasing
        a. The main reason given as a possible explanation is that Region I is only reporting IPP funded tests whereas most regions report all tests done at a

given IPP supported facility regardless of source of payment

F. Lunch and State Meetings
G. State Report Backs
    a. Massachusetts
        i. Massachusetts would like to the change risk factor data collected to "STD in previous 12 months"
        ii. Progress toward objectives
            1. Massachusetts is recruiting more sites in the hope of increasing CT screening by 10%
            2. Massachusetts discussed objective 2.2 briefly and will let providers know that no more than 5% of women over age 25 without risk factors should be screened in IPP clinics
        iii. Massachusetts likes the posters
        iv. Massachusetts has no interest in developing a unique ID
        v. Massachusetts passed EPT legislation and is waiting for the regulations to be updated to reflect the new legislation
        vi. Jamie Holland is filling in for Linda Han
        vii. Laura Smock is the new Massachusetts IPP Advisory Board Member
    b. Connecticut
        i. The STD definition doesn't apply to Connecticut since they are only screening women under 26 regardless of risk
        ii. Progress toward objectives
            1. Connecticut will probably see a decrease in CT screening (in part due to expanded Medicaid coverage)
            2. Objective 2.2 is not applicable
        iii. Connecticut likes the provider materials and is looking forward to using them
        iv. From a lab perspective, Connecticut is not able to implement a unique ID
    c. Rhode Island
        i. Barbara McNeilly will confer with Mike Gosciminski and get back to JSI about Rhode Island state issues
    d. Maine
        i. Maine would like to the change risk factor data collected to "STD in previous 12 months"
        ii. Progress toward objectives
            1. Maine is not sure it will be able to increase CT screening because it just cut sites (that weren't meeting the 3% positivity criterion)
            2. Maine will discuss objective 2.2 in greater depth (maybe it shouldn't screen those over 25?)

iii. Maine is happy to have JSI's assistance with rolling out the provider materials
iv. Maine is interested in developing a unique ID, especially with regard to re-screening
v. There have been a lot of Maine FP changes – e.g. EPT passed in July

e. Vermont
i. Vermont would like to the change risk factor data collected to "STD in previous 12 months"
ii. Vermont will give Jaya an update on its lab slip changes
iii. Progress toward objectives
1. Marketing will play a role in achieving objective 1.1
2. Regarding objective 2.2, Vermont DPH reviews lab slips to ensure that screening criteria is being met (if not, DPH calls the vendor, which Vermont will continue to do)
iv. Vermont thinks the provider materials are great, and also appreciates that JSI will help with training
v. Vermont is not sure how applicable a unique ID would be, though it is looking into internal mechanisms to track re-screening
vi. Vermont is trying to expand school-based testing (there are some good models in DC and a new STD screening pilot project at Burlington High School)

f. New Hampshire
i. New Hampshire would like to the change risk factor data collected to "STD in previous 12 months"
ii. Progress toward objectives
1. The lab shows a potential increase in CT tests, but overall New Hampshire is seeing a drop in the number of teens screened (teens might be getting tested in primary care, teens might say no to a CT test, New Hampshire had a site closure, etc.)
2. New Hampshire believes it is making progress on objective 2.2, which is attributable to provider training (New Hampshire has been pushing the screening criteria with its sites, and also does QA on lab slips that aren't clearly marked)
iii. New Hampshire is interested in distributing provider materials to all FP and STD sites (not just IPP)
iv. New Hampshire is interested in developing a unique ID
v. EPT is permissible in New Hampshire, but not legalized (state STD provides medication, but it is up to providers whether or not to disseminate them)
vi. FP is adding two measures in FY 2011 (treatment and re-screening) for all sites, not just IPP sites

Lab Subcommittee Meeting

A. New Hampshire is doing the turnaround pilot (not Connecticut)
B. Bob Ireland could not be here due to a knee injury
C. Rick Steece Update re: Letter from Dr. Fenton
    a. A letter from Dr. Fenton was sent out recently
    b. Background Information
        i. Walsh and Peterman did some investigation into CLIA inspectors in New Mexico who were preventing labs from bringing in new technology, shutting down the Arkansas state lab, etc.
        ii. New Mexico labs were repeating specimens that were close to the cut-off and the inspectors cited the labs
        iii. On their own, the labs decided to stop doing repeat testing
        iv. Arizona labs and a lab in Texas thought the inspectors would cite them as well, so they also decided to stop repeating specimens close to the cut-off
        v. Walsh and Peterman became nervous that all people near the cut-off that did not receive repeat testing were positive and thought it was necessary to bring them back for re-testing (though there was no data to show that this was a widespread problem), and wrote a letter to this effect
        vi. Walsh and Peterman sent out a questionnaire to labs to see how common specimens near the cut-off were, but did so only after they had sent out the letter
    c. There was a large negative response to the letter from IPP lab representatives throughout the country
    d. The CLIA inspectors responsible for the citations had a strict interpretation of CDC guidelines
    e. Labs are testing based on the existing CDC screening guidelines, though they are moving toward no repeat testing (based on the new guidelines that will soon be released)
    f. Walsh and Peterman sent out another letter to the STD program managers (with most of the same content from the first letter), and recently disseminated a Q&A to address any outstanding questions
    g. CDC said years ago to repeat if you feel you have to, and therefore labs do so when they feel it is necessary (though generally there is now more of an understanding that any amount of repeat testing will still yield false positives and false negatives, so repeat testing is not necessary)
    h. In Region I, Maine, New Hampshire and Vermont are still doing repeat testing
    i. There may still be more clarification coming from CDC
    j. An CDC Incident Review Committee has been developed and is preparing a narrative of these events to give to CDC administrators

k. Rick thinks that CDC will probably let the guidelines address the issue from here on out
l. Labs should either follow the product insert or use internal data to show that repeat testing is acceptable (i.e. follow current guidelines)
m. There is no guidance for how to report repeat testing, so Rick encourages labs that plan to repeat to repeat once and call it "indeterminate" or "equivocal"
n. If labs are doing repeat testing with the same test type, they should provide clinicians with only one test result and interpretation
o. New Hampshire data review
    i. New Hampshire looked back to 2004 at specimens that were initially positive, retested negative, and retested again and were negative
    ii. There was a total of 190 specimens that followed that pattern
    iii. New Hampshire then looked at patient records to see if the lab received another specimen for those individuals at another point
    iv. Out of the 190, 77 patients had specimens submitted in the future
    v. Out of the 77, 4 were positive
    vi. New Hampshire will pass this data along to Rick
p. When NAAT (Nucleic Acid Amplification Testing) testing started, there was concern among labs that there wasn't proper quality control
q. Of those states still doing repeat testing, are any moving toward stopping?
    i. Maine will keep conducting repeat testing for the foreseeable future
    ii. Connecticut
        1. Connecticut made the decision not to repeat, because it thinks there will always be a small number of false positives and negatives
        2. Connecticut also has an issue with how "indeterminate" results are reported*
    iii. New Hampshire will wait for the new CDC guidelines to review its practice of repeat testing, but it intends to stop repeat testing
r. Lab could consider drafting a letter for clients defining "indeterminate"

D. Transit time Study
    a. Lab representatives will report on 500 samples in February 2011
    b. Transit time is defined as the date of specimen collection to the date the specimen is received at the lab
    c. Arthur Kazianis will send out a reminder to the subcommittee before the beginning of the transit time study
    d. Arthur distributed a transit time study template to the subcommittee, which everyone thinks looks good
E. Draft Offenders Letter

a. Arthur drafted an offenders letter, which is still in draft form for those who do not meet the turnaround time
b. Arthur is more than happy to accept people's feedback and send a draft out to subcommittee for approval
c. New Hampshire lost its courier this past summer, so it is seeing more specimens coming beyond 6 days after collection
d. New Hampshire and other states may need to tell sites to send specimens soon after collection and not just when they fill the mailing containers
e. Arthur will reword the offenders letter to make it clear that IPP is interested in the timely treatment of patients and contacts (i.e. the goal is to treat patients within 14 days specimen collection)
f. The subcommittee aims to finalize draft by the end of 2010

F. Reproducibility Study
   a. Lab will no longer conduct the reproducibility study as they are consistently high performing
   b. There is the potential to conduct this study as a special project in the future, if necessary

G. Study Pilot
   a. New Hampshire did a pilot study for the month of May (before the state lost its courier) and August (after it lost its courier)
   b. The goal of this pilot was to see if providers are given enough time to treat patients
   c. There is not a huge discrepancy between the two periods
   d. Six days from the date of collection, the percentage of results that had been reported to the clinics:
      i. May – 75%
      ii. August – 72%
   e. New Hampshire will continue to monitor this and will let the subcommittee know the results

H. Turnaround Time Study
   a. Arthur hands out a summary of turnaround time data for all Region I states
   b. The Vermont data looks incorrect – Eunice Froeliger will look into this and get back to Arthur

I. June Meeting Speaker Ideas
   a. Linda Niccolai was an interesting speaker
   b. Mark Pandori of the San Francisco Department of Public Health could discuss about genotyping
   c. A representative of the Association of Public Health Laboratories could be a good speaker
   d. John Papp might be able to recommend other possibilities

Screening and Treatment Subcommittee

A. STI Variable Discussion (and how to communicate change to sites)
    a. Group discussed this variable and came to the consensus (minus Connecticut) to change STI variable to "STI in past 12 months". Group felt that a webinar, done state by state would be necessary and helpful. They also hoped this could be an opportunity to remind of risks and screening guidelines.
    b. Webinar should be: short and during lunch hour
    c. Also if possible please post webinar and/or slides online for those who may miss it.
    d. Also proposed was some written cover letter / handout / memo to let them know lab slip changes are coming
    e. It is expected that the data from new variables will not be reliable in the first 6 months (at least)
    f. Timeline: new database and lab slips developed by JSI in December and rolled out in January
B. Cost analysis tool
    a. Tool draft was passed out and will also be emailed out.
    b. Intended to be one more tool to help explain the need for adherence to guidelines
    c. Results will show % of budget spent outside the guidelines
    d. JSI is asking each state to do it and a regional profile will be compiled.
    e. JSI will be organizing a webinar to walk through the tool which Jennah piloted in Maine
    f. Positives are not subtracted from total as each state can see how many positives the total spent outside of guidelines yielded, it is usually quite low
C. Facility Specific Data Reports
    a. Second part of initiative to increase adherence via providers
    b. First draft circulated; the group likes the simplicity and thinks they will be useful
    c. Suggested additions: possibly trend line to see progress and possibly race and ethnicity
D. Further Discussion on: Facility positivity rates and Falling testing numbers
    a. See state reports
E. Progress on GC Action Plans
    a. NH wants to explore a way to add GC to only Hillsborough County lab slips or add a Hillsborough County check off on lab slips
    b. Maine wants to reach out to FQHC's but with only 106 cases it is not everyone's priority
    c. Wants to do a fall mailing after the 2010 STD Treatment Guidelines are released.

    d. VT trying to be aggressive in follow up and interview all cases at time of treatment
    e. VT is working with HIV prevention providers working with MSM and communities of color to try to get them to incorporate GC messages
    f. MA has had an increase in GC especially among older men
F. Is there a way to come up with unique ID for CT patients that could be used for tracking re-screening?
    a. VT, NH, ME are all interested in participating in a pilot
G. Supplemental Funds
    a. The group discussed that the supplemental funds will be coming out soon to project areas and the possibility of joining together as a region in a single or coordinated effort
    b. Possible ideas included: exploring ideas around utilizing the social network of positive individuals using lessons learned from HIV prevention – and targeted screening of the social networks of positive individuals
H. Agenda items for next meeting: none suggested.

<u>Next IPP Advisory Board Meeting</u>

- Planned date: June 6 & 7, 2011 in Wells, Maine
- Possible speakers / topics:
    a. Someone like Linda Niccolai would be good (it is interesting to hear new research)
    b. See lab subcommittee suggestions