Region I IPP Advisory Board Meeting
June 6 & June 7, 2011

Combined Screening & Treatment and Data Subcommittee Minutes

Participants
Heidi Jenkins (CT)
Susan Lane (CT)
Marcy Moyel (MA)
Roberta Moss (MA)
Christina Lombardo (MA)
Elizabeth Torrant (MA)
Hillary Johnson (MA)
Laura Smock (MA)
Brenda Cole (MA)
Lynda Sampson (MA)
Sarah Elie-Bennett (ME)
Evelyn Kieltyka (ME)
Michelle Ricco (NH)
Lindsay Pierce (NH)
Barbara McNeilly (RI)
Mike Gosciminski (RI)
Daniel Daltry (VT)
Rebecca Levasseur (VT)
Steve Shapiro (CDC)
Andee Krasner (JSI)
Jennifer Kawatu (JSI)

A. Group structure review
    1. The subcommittee is looking for another co-chair
    2. This subcommittee decided to remain one committee for efficiency sake
B. Improving adherence to screening guidelines – what are the state strategies?
    1. The NH lab monitors incoming lab slips and calls sites when there is missing information
        a. NH lab sends bills to sites for labs submitted for clients outside screening guidelines. Found that sites very quickly became compliant with screening guidelines.
        b. NH may transition to not screening 25+
    2. Conn bills sites for any woman tested 26 and over
        a. If there is a lab slip for someone 26 or over, those tests get billed not as IPP but billed directly to Planned Parenthood quarterly
        b. The state lab handles this billing process
    3. VT has become stricter in enforcing guidelines with clinical staff
        a. Site mangers have had increased accountability for work outside of guidelines
        b. There has been more oversight over the last year and a half
    4. Conn's issue is trying to get all of the *eligible* ages in to get screened
        a. This is especially the case in the PTO setting and delayed pelvic exams
        b. Conn is serving about 50% in the 15-25 age group, so there seem to be missed screening opportunities
    5. Documentation can also be a challenge
        a. The IPP lab slip form is used as a lab requisition form in most states throughout the region

   b. However, the issue is that clinicians do not want to fill out all fields if it is not an IPP specimen
   c. NH switched to LIMS and now have electronic files as well as paper (though looking into a paperless system)
   d. Some LIMS systems do not have all variables required by IPP

C. Billing
   1. RI and NH can direct bill clinics
   2. ME is working with the lab to back-bill for patients who are not eligible under the screening criteria
   3. There is a possibility for MA to bill out of the state lab
   4. There is an expectation and hope that STD clinics, family planning sites, and labs will all have billing capability/capacity

D. Revision of Regional Goals and Objectives
   1. OBJECTIVE 1.1
      a. Change 1.1. from 'increase' to '<u>maintain</u> CT screening'
         i. 'Increase' is unrealistic as the region is dropping in the volume of tests performed each year (this may be due to population changes, however in MA for example it also could be the fact that people are using insurance instead of IPP for funding screening)
      b. There is the possibility of adding sites to IPP
         i. States can do more targeted screening by adding PTO, and creating other screening opportunities
         ii. MA is in discussion to add more sites but it is happening slowly
      c. In 2010 the only increase was RI, which added 3 sites
      d. MA added 6 sites but its testing numbers still dropped last year
      e. The goal for 2012 will be to maintain 2010 numbers (measured by calendar year)
   2. OBJECTIVE 5.1
      a. Change to '<u>within</u> 3-<u>6 months</u>' from '3-4 months' of completion of treatment
      b. There is baseline data for ME, MA, and NH but not all states
         a. Therefore, wording should be changed to: <u>For states that don't have baseline data they need to get it. For states that do, aim for 5%.</u>
      c. Providers can ask for dates during the rescreening process and try to track number of months between the initial screen and rescreen
      d. Language should be added saying that IPP will '<u>improve tracking capability</u>'
         a. At the clinician level, providers should check the box for rescreen from 3 up to 12 months (and do this consistently)
      e. Positivity should also be built into priority area 5

E. The subcommittee should revisit development of the regional performance measures at the Sept subcommittee meeting