

Main Meeting

Participants

Lisa Marvinsmith (CT)	Lynda Sampson (MA)	Eunice Froeliger (VT)
Gary Budnick (CT)	Brenda Cole (MA)	Daniel Daltry (VT)
Heidi Jenkins (CT)	Sarah Elie-Bennett (ME)	Jennifer Kawatu (JSI)
Marcy Moyel (MA)	Evelyn Kieltyka (ME)	Andee Krasner (JSI)
Arthur Kazianis (MA)	Jemelie Bessette (ME)	Jaya Mathur (JSI)
Roberta Moss (MA)	Lindsay Pierce (NH)	Marie Kaziunas (JSI)
Laura Smock (MA)	Michelle Ricco Jonas (NH)	Hallie Tuchman (JSI)
Christina Lombardo (MA)	Bob Ireland (RI)	Steven Shapiro (CDC)
Bryanne Wainford (MA)	Barbara McNeilly (RI)	Lizzi Terrone (CDC)
Tracy Stiles (MA)	Brittany Isabell (RI)	Kathy Desilets (DHHS)
Elizabeth Tarrant (MA)	Sarah McGinnis (VT)	Natalia Guevara (DHHS)

DAY 1

- A. Welcome & Introductions (JSI)
- B. Increasing Rescreening Rates Presentation (Susan Mancuso)
 - a. Background Information
 - i. Susan Mancuso worked in obstetrics, before starting at Buffalo University. She has been working in Infertility Prevention for a long time.
 - ii. The University of Buffalo is the biggest university in the SUNY system. There are both undergraduates and professional students, ranging from ages 15-80. We have both international and domestic students and a total of three campuses.
 - b. Health Services at University of Buffalo
 - i. Health Services is a non-fee service (unlimited, free access). Students must be registered to receive services and they can't use services for an unregistered significant other. Health Services is mostly staffed by nurse practitioners, and some doctors.
 - ii. On campus the second most common ICDs are sexually related.
 - iii. Students that came to get tested were uninsured or afraid to use their parent's insurance due to EOB. The biggest population we served was White (mimicking our population demographic on campus). However, highest positive tests were for Black males.
 - c. Testing & Drug Resistance Concerns
 - i. Initially we had no way to get test results (or to do anything beside a urinary with white cells). If you had a certain count, and physical symptoms we would treat you for CT and GC. We knew we could be causing drug resistance, but had no other testing method.

- ii. Susan Mancuso wrote an e-mail to President about these concerns, and was able to obtain funding for a better system. This began a baby-step approach of improving the quality of care through CQI..
- d. Reporting/Treatment Errors and EMR Use
 - i. Errors in reporting and treatment, led us to get an EMR system called MEDICAT. It was primarily good for progress notes.
 - ii. We thought with the EMR we would be more successful, and we have been overall.
 - iii. When there is a positive communicable disease result, they get sent to a designated RN. The same nurse completes all the forms required by county.
 - iv. We also started using an excel spreadsheet with test and demographic information around the same time.
- e. After QCI Changes – Phase I
 - i. With the new system in place and using the variables on the excel spreadsheet – we thought we had the worst retesting rates. Also we found that the students that did come back were positive again.
 - ii. The first outcome was 107 people tested in 15 months. Of these, 28% retested for TOR and 13% were missed opportunities. There was a 17% return rate, and we were overwhelmed by this.
 - iii. Additionally, less men than women were retested.
 - iv. The ECHD Medical Director came and talked to staff about the importance of rescreening and said to try to stick to a 42-90 day period for retesting. She discussed how every clinic in NY State was around a 17% return rate. Also, she discussed nucleic acid amplification tests and not testing too early with them.
- f. Phase II: Changes and Results
 - i. The Medical Director wanted to keep up morale, so she offered to send out e-mail reminders and support the excel spreadsheet method.
 - ii. Postcard reminders don't work with students. Also, we found postcards to be problematic in terms of confidentiality because student interns sort mail before staff. For these reasons, we decided to do e-mail reminders instead.
 - iii. There were 57 positives, of which 32 came in for retesting (9 of which because they had another STD). In sum around 40% came back in for 'test of reinfection' testing.
 - iv. In Phase II, rates went down and re-testing went up. However, testing within the 90 day period did not increase, and we were upset with this result. One person was tested too early (at 7 days).
 - v. More men came in to get tested. However, fewer women came in to get tested during this phase.
 - vi. A big issue during Phase II was morale; the nurses didn't want to talk to students. They would send them to the Chlamydia Specialist (i.e. Susan Mancuso). The students weren't responsive to their e-mails, and this was demoralizing.
 - vii. After talking to the Medical Director about these issues of non-responsiveness. She asked that I talked to all 3 positives in order to learn what they were thinking and the barriers to testing. They were all 'not aware' of many things related to testing, treatment and the STDs.. They didn't understand when they could have sex after taking Doxy or Azithromycin. They didn't know they needed to contact people they had sexual relations with 6 months before. To me this demonstrated that there were tremendous gaps in education.

- viii. When I discussed this finding with the Medical Director, she advised me to try to reach the students and learn more about the barriers. We couldn't do much because of confidentiality however we could reach out to phone companies and find out why phones were disconnected –sometimes because they had not paid their bills. We found that they didn't open up e-mails if they didn't recognize the sender name and they were afraid of viruses. Their providers mentioned coming back for retesting, but it was in a casual way and to the students it didn't seem significant. We also found that some students had gone off campus to another clinic to get retested.
- g. After Phases I and II
 - i. After reviewing our collected patient information with the Medical Director. I saw there was a big difference between providers that see males vs. those that see females. Also, those that are female providers (see females), would offer to have a script called in and there was no discussion with the patient. Female providers only used telephone contact, as they felt like they didn't have the time to have the students come back in.
 - ii. I notified the Medical Director of these findings and asked for her support and that of NY state. As a result, she contacted Cicatelli for assistance. We did telephone conferences between all parties. After explaining first how our department worked, Cicatelli reanalyzed all the data compiled by SUNY staff and by the county. We discussed concerns via phone and e-mail.
 - iii. Cicatelli wanted to do focus groups to see if there were trends. However, these have never been successful at the University; students don't want to talk about personal things. We couldn't even get interns to do it.
 - iv. The county uses incentives to gain participants. We couldn't do this though because the University was against it.
 - v. EPT was also recommended. However, the SUNY Council (legislative body) would not allow EPT. They would allow contacting students, but not distributing scripts.
 - vi. Improving education within the limited appointment time was worked on.
 - vii. We looked at adjusting the time frame for rescreening for our population.
 - viii. We also did a test of texting reminders with three people. We found through the test that, sometimes the person calling back was not the student patient and so texting breached confidentiality and so we felt texting was not the solution.
 - ix. We did add a 'follow up appointment' in the EMR records. This has helped with follow ups.
 - x. Why did male-factor improve in phase II? We believe the answer was personal contact!
- h. Phase III: Changes
 - i. Having one person be 'the contact' was important to success.
 - ii. We instituted that all patients must come back for an appointment and stopped offering phone scripts.
 - iii. We used a treatment incentive 'free oral or IM medication". This eliminated the need to use insurance, cash or worry about parents.
 - iv. In terms of an education initiative, we formulated a GC/CT Positive Letter to get information to the students. In our EMR, if you are positive the letter is available for the provider to print. Additionally we send students to the CDC website.

- v. We changed the return visit time frame to 25-55 days, so that vacation and term lengths didn't adversely affect people coming back in for a follow up appointment.
 - vi. We also would send reminders with parking passes to help facilitate students to come back.
 - vii. Excel spreadsheet is used, there is also one person to make sure correct medication and procedure was used. Also, uses MS Outlook, that sends reminders to providers and then the providers remind students.
 - viii. If students don't want to get reminders through University e-mail, we will use another e-mail or any provided contact information. We only send one reminder now and for minors or pregnant women we notify the county if they don't respond.
 - ix. If an individual is still positive on the return visit, the whole system starts again.
 - x. We do refer to other clinics/health departments. Also send students to the GYT website. I also include provider contact information for students that live elsewhere, or graduate.
 - xi. We have an instituted phone call script – that protects confidentiality and refers students to e-mail, as opposed to discussing confidential information over the phone.
- i. Phase III: Results
- i. We had an age range of 17-39 for positive patients. We had 41 of 41 positives have a brief return visit. We went from 17% (phase I) to 16% (phase II) to 95% (phase III) return rate within 90 days. Additionally, we had a few positives on the return visit. The highest incidence was in men.
 - ii. For females we did have one missed opportunity, however we were able to follow up with her and she saw a GYN at home. We also had one missed opportunity for males. Also, there was the issue of qualification with a patient; however we were able to send them to a different clinic.
 - iii. There was an improvement for being seen within the ideal time-frame. Everyone came in prior to 90 days.
 - iv. 100% of those that qualified in the spring semester (that also tested positive) came back. Also many that weren't qualified went elsewhere. In Phase III not one person came back with signs and symptoms. Individuals even came back without reminders, and some brought partners with them, after reading the letter. Even students with partners outside of NY and the University came to the clinic with concerns and asking where their partners could get tested.
 - v. People also referred to the letter in relation to concerns regarding reactions to medication.
 - vi. There has been an increase in staff morale which has been very positive. The staff have been very happy with the positive results.
 - vii. However there still remains the issue of Provider and staff time.
 - viii. The 2 patients that were still positive on the return visit had long distance relationships.
 - ix. If we had pop-ups in the EMRs some of the missed opportunities, would not have been missed.
 - x. There were timing issues with e-mail (notifications occurring when students were sleeping etc.) but much of this has been since resolved.
 - xi. There is a documented Phase III protocol now that requires involving the CT/GC specialist.

- j. Duplication
 - i. The big difference between phases was that providers didn't buy into the protocol at first.
 - ii. You need to have a central person, if you have a multifaceted clinic.
 - iii. We have retooled the protocol after it was established. Doing this makes EMR easier.
 - iv. The central coordinator needs access to Excel and Access/and electronic calendar for reminders.
 - v. Asking people how they want a reminder is also very important.
 - vi. It takes baby steps to improve the system and we see improvement each semester and year.

- k. Publicity
 - i. We had a publication in JAMA and this was also a morale booster.

- l. Q&A
 - i. Inspot.org is a website provided by CDC, where you can inform partners anonymously. The confidential website is GYT – you have to put your zip code in and they will give you location of clinics within 5-10 miles away.
 - ii. Our University e-mail is encrypted. However, these changes after you graduate. That is how it gets past HIPPA.
 - iii. Factors for improvement:
 - 1. We think in person contact, education and treatment – emphasizes that this is something significant to patients
 - 2. Handing out information and changing time frame. Narrowing down the time-frame was significant – the further away an appointment is, the less significant.
 - iv. We have high initial screening for our area (according to the county) and so we don't do as much outreach.

C. CDC Update (Steven Shapiro)

- a. CSPS 2013-2014
 - i. Last year of the 5 year STD Prevention grant
 - ii. Guidance published two weeks ago
 - 1. Application due August 20th 2012 (grants.gov)
 - 2. Project areas have 90 days to respond
 - 3. Minimal write up application
 - a. Narrative and table (2-4) are to be no more than 30 pages
 - i. Budget pages don't count towards the page limit
 - b. Up to 20 pages for appendices
 - i. Good space for objectives etc.
 - 4. Funding levels: hope they will be at 2012 levels but don't know what they are right now
 - a. Possibility of 1.89% rescission in which case might have to readjust 2012 budget in that case
 - 5. Also asking for a special needs budget for 2013 (up to 25% of the total base award)
 - a. This way, will not need to have an additional application if the opportunity arises to fund special projects.

- b. Project needs to address STD prevention priority
 - c. Should be investment in STD prevention where this is the only money you are going to get
 - i. no new hires/ salaries should be used with this money
 - ii. No guarantee for this money in 2014
 - d. Will need an IPP letter of concurrence (Same as always)
 - e. Need to have measurable outcomes and demonstrate effectiveness
- iii. Performance measures are now optional
 - 1. Encourage you to collect performance measures if it is helpful for your program
 - a. if you do please submit them to the performance measures database
 - 2. Performance measures were built into CQI capacities and have them represent program, if report in one area, will report to CDC as well
 - 3. Additional guidance on STD project for directors/ program managers and epidemiologist will be required to attend one regional or quadrant meeting in 2013
 - a. These 3 positions or the appropriate number from your state
 - b. Required to participate in program webinars and conference calls (a little different from the past)
- iv. Other comments
 - 1. IPP plan must be developed in partnership with family planning and laboratories partners
 - 2. Need to submit plan to JSI with enough time for them to review it
 - 3. Any carryover requests should be submitted now
- v. 2014 will probably not be called CSPS
 - 1. Anticipate significant changes
 - a. There will a page limit (more than 30 pages but it might not be)
 - b. Will be able to use calendar year 2012 data
 - 2. CDC dollars being used for your state and local prevention plans
 - a. if you don't have a prevention plan, should work on getting one
 - 3. Need to make the case for deviations from CDC recommendations as to why they are not applicable to your state
 - 4. Application guidance will be published March 1st 2013
 - a. Applications due May 13th 2013
 - 5. Hope that funding announcement will be announced at the end of the year
- vi. Having a consultation with national partners in July
 - 1. Will have representatives from region 5, 8 and 10
 - a. Asked to identify 6-7 project areas
 - i. 2 large, 2 medium, 2 small
 - b. Have also asked other professional organizations
 - i. Dr. Bolan needs to talk to national partners who don't get funding about STD prevention and decide how to structure this new funding opportunity
 - 2. Opportunity to tell Gail what you think on how the FOA should be structured
 - a. Can email her at DSTDPCPS@cdc.gov

4. Contact National Academy of State Health Reform with questions about methodology
- ii. Effects on STD prevention
 1. Dr. Bolan has been very clear that the direction of STD prevention has to be on assurance, policy development, assessment and accountability, safety net coverage.
 - a. State STD programs will not be providing direct service
 - i. not expected to be in the business of using federal dollars to buy direct service
 - b. Every state program should have an STD epidemiologist on staff
 - i. Could be purchasing time of the current state Epidemiologist
 - ii. Could be a requirement of the FOA
 2. Assurance
 - a. Surveillance system that is functioning beyond data collection and management
 - i. Used to analyze data and program planning
 - b. Local Epidemiology Support
 - c. PCSI should be incorporated in all program plans
 - i. language included in all FOA
 3. Policy Development
 - a. Plan programs using data –all sorts of data
 - b. Going to need data beyond morbidity and case counts
 - i. Need census, SES data to fully understand the populations
 4. Assessment and Accountability
 - a. Can't really fund projects that are not evidenced based
 - b. Monitoring and Evaluation
 5. Safety net coverage
 - a. How do we assure that services are not covered under the HIEs
 - b. Kids ages 0-10 are heavily monitored, cared for and educated and from ages 10-19 it is sort of a black box
 - i. Need a "safety trampoline" (lift back up) instead of "safety net"
 6. Strategy priorities
 - a. National prevention strategy
 - b. National HIV/AIDS strategy
 - c. Preventative Services for Women
 - d. Winnable battles
 - e. Infrastructure and capacity building
 - f. Preventing through healthcare
- d. How the FOA fits into this
 - i. Activities most interested in:
 1. Screening and testing
 - a. through guidelines and policy development
 2. Linkage to care
 - a. DIS may be embedded into large practices such as might be enrollment counselors for state Medicaid program

3. Partner Services (especially internet partner services)
4. Health promotion
- ii. Priorities:
 1. Adolescents and Youth
 2. MSM
 3. MDR GC
 4. Congenital Syphilis
- iii. The future of IPP
 1. Report being worked on
 2. An infrastructure driven evaluation
 - a. IPP in the project areas
 - b. Environment scan
 3. Recommendations for the future
 - a. Document outlining these details will be coming soon
 - b. Decision Analysis process
 4. Current infrastructure grant with OPA ends on June 29th
 - a. OPA has decided to go from 10 regional planning training centers to 4 national regional planning centers
 - b. CDC has no mechanism to continue to fund infrastructure as it is
 - c. IPP infrastructure ends as of June 29th
 5. New joint FOA with OPA that was published in April 11th to be submitted June 11th
 - a. Hope to fund on August 1st
 - b. Part A: OPA is funding Family Planning Training Centers all focusing on a different issue
 - i. There is a list of eligible agencies. There are requirements with experience etc.
 - ii. Agencies can apply to all 4 (all separate applications) or can focus on one or two
 - iii. OPA will review those applications
 - c. Part B: CDC funding STDRHPTTAC
 - i. CDC will be reviewing those applications
 - i. There will be an objective review panel
 - ii. Hope to fund by August
 - d. CDC has approved all the NCE for IPP so that they can continue IPP activities through August 31st
 6.
 - a. Prevalence monitoring is no longer a funded activity in the new FOA at the national level
 - i. Get a limited number of variables nationally
 - b. Feel the data is more useful on a regional and local level
 7. After 2013 it is up to you whether you want to continue to collect The new FOA includes transition assistance with how to collect, manage, and use the data
 - a. Not sure what is in store for IPP in 2014
 - b.
 - i. Talk about rolling up IPP as a base award

- c. Advantages and disadvantages to both
 - i. There is an opportunity to let Dr. Bolan know how you think
 - e. Gonorrhea
 - i. Increase in proportions of isolates with Elevated MICs to Cefiximes
 - 1. Will probably be over 5% for MSM for this year
 - 2. There are some clinical trials underway now but results are unknown
 - a. Additional slides will be provided after the meeting on the website
 - f. Q&A
 - i. Part B Training and Technical Assistance: there will be up to 10
 - 1. National Family Planning Training centers: there will be 4
 - 2. Activities include billing and reimbursement TA, best practices TA
 - ii. Grant period will be a 5 year project period for Part B, 4 year for Part A.
 - 1. 12 month budget
 - iii. This is the last meeting of IPP in Region I.
 - 1. STDRHPTTAC will involve a broader group than STD and Family Planning
 - iv. Can contract with JSI to do some of the data collection work if you are interested
 - v. In terms of Evidence Based Practices: May be an opportunity to use some dollars for research (research science part).
 - 1. If a FOA goes out for program purposes cannot be any research in it, which would be a different FOA
- D. State Report Backs
 - a. Connecticut
 - i. Connecticut is happy that prevalence monitoring is stopping – they’re not using the IPP data much
 - ii. Connecticut doesn’t collect risk factor information – even if they did, they would still screen the same population
 - iii. All Planned Parenthood sites – females 25 and under and male partners
 - iv. Three STD clinics (will remain this way)
 - v. Anyone 26 and over or male will be put under PP account with state lab
 - vi. PPSNE has electronic medical record set up – STD and family planning programs get data out of the EMR
 - 1. Testing data – everyone 25 and under was tested
 - 2. Rescreen data
 - 3. Race and ethnicity data
 - vii. Effective June 1st – section chief for HIV program will be in charge of HIV, STD & TB
 - viii. The state lab is moving soon
 - 1. The lab is moving in phases
 - 2. Inspection is taking longer than expected
 - ix. Nothing has changed with STD clinics – funding has not been cut for next fiscal year
 - x. ACA
 - 1. Look forward to training & TA
 - xi. Have a new TB Medicaid program
 - 1. Go through DSS and get people who are uninsured and eligible
 - 2. Under Medicaid just for duration of their TB
 - 3. Providers are learning how to be Medicaid providers – which is a good learning process considering upcoming changes

- b. Rhode Island
 - i. There is no Program Manager right now – hopefully will be filled in next few months
 - ii. STD clinic closed July 1st 2011
 - 1. Did a provider mailing with EPT, epi info, new case report form
 - 2. There are workgroups that have been started to address STD issues and share resources
 - iii. FQHCs have reached out – many clinics won't use EPT for insurance purposes
 - 1. Have added question on report form re: whether providers use EPT – will be interesting to look at data
- c. Massachusetts
 - i. Concerned about loss of regional training center, which has provided important services
 - ii. Family planning is still picking up slack from closing of STD clinics
 - iii. Trying to ensure that state lab will still be fiscally viable
 - iv. Testing will likely go down
 - v. Significant number of patients who don't provide insurance at the time of service – concerned that there is nothing replacing safety net – after health reform
- d. New Hampshire
 - i. No new funding news – still no state STD funding
 - ii. Lab staff do data entry for IPP right now
 - 1. Not sure what will happen re: what they collect for data
 - iii. Now STD and FP performance measures match, so will have a better data set
 - 1. Will be an advantage given that they're losing other data sources
 - iv. Continuing to strengthen public health referral networks
 - 1. DIS referrals
 - v. Limited federal HIV funds and partnering with viral hepatitis and HIV programs to put out RFP with 3 agencies in southern NH to do targeted hepatitis C and HIV testing and will accept DIS referrals
 - vi. Have focused in last 6-9 months on analyzing data
 - 1. A few epis are helping to look at this data
 - 2. Want to replicate a study done in MA to look at ICD-9 diagnosis
- e. Looking for intern. Maine
 - i. STD program now have surveillance coordinator and prevention coordinator
 - 1. Otherwise, same staff and funding
 - ii. Governor proposed in last legislative session to eliminate Medicaid funding to STD programs
 - He doesn't need a waiver for this to go through
- f. Vermont
 - i. PPNNE is upgrading their systems, including their offices
 - ii. PPNNE is moving toward electronic lab reporting system, which will help them look at data better internally
 - 1. Slow roll-out
 - iii. The state received a grant through Medicaid (The Access Program) - \$2 M to PPNNE to help people without insurance access care
 - 1. These folks were formerly covered by IPP (so IPP testing trend is down)
 - iv. ACA
 - 1. Curious where the Department of Health will be at the table re: insurance

2. What's the necessity of 340B going to be?
3. Getting Azithromycin at 80 cents per dose and doxy at \$1.40 per dose
4. If no longer have private or federal funds for treatment, DH will be challenged to provide services

E. CDC Data Presentation (Lizzi Terrone)

a. Background info

- i. Catherine Satterwhite was the epidemiologist for six years
 1. Took position at KU Medical Center
 2. Still has a relationship with CDC – will work with local partners to write up their data analyses and publish it
 3. People should email her if they want her help
 - a. Could also be ideas of work you want to do
 - b. If anyone wants to write up data from national data set, just need to contact Lizzi and sign release form – CDC wants the data to be used
- ii. Lizzi started out doing AmeriCorps
 1. Worked at the Carolina Health Alliance
 2. Went to UNC for PHD
 3. Did fellowship at CDC EIS, placed in DSTDP
 - a. Sent her out on EPIAid, including Alaska re: gonorrhea control

b. Data

- i. Chlamydia case rates
 1. Rates among African Americans is elevated
 - a. Changed reporting of race/ethnicity in surveillance reports
 - i. Case rates are only among cases with known race/ethnicity (since 2010)
 - b. About 26% of cases miss race/ethnicity
 - i. More likely among lab reporting
 2. Case rates highest among 20-24 (used to be 15-19)
 - a. Possibly because screening more people in this age range
 3. For women, most case reports of chlamydia come from private setting
 - a. For men, an increasing number of CT cases diagnosed in private sector
- ii. What data tell us
 1. CT most commonly reported STD
 2. Doesn't account for changes in screening coverage, test technology used
 - a. HEDIS measures, only a handful cover just Medicaid population – CT screening coverage is one, so can see broken out by HMO and Medicaid
 3. In National IPP data, see that almost 100% of tests now are NAATS – diagnosing better because NAATs is more sensitive
- iii. What do CT case report data tell us
 1. Incidence and prevalence of CT
 2. Duration of infection is unknown
 3. Doesn't account for changes in screening coverage, test technology used, empiric treatment, reporting practices
 4. Difficult to interpret national case report data, so look to other data sources

- iv. Look to IPP
 1. Can tell positivity (not just number of positive tests)
 2. CT and GC testing have gone up (perhaps in part to reporting increases)
 - a. Overall, 1.1 M tests conducted among females 15-24 in FP – slight increase between 2009 and 2010
 - i. Slight decrease in Region I
 - ii. Region IX had huge increase – because they were able to send CDC more testing data – not because doing more testing
 3. Positivity has steadily increased
 - a. Except Region IX’s positivity has gone down significantly (but probably just an artifact of increase in reporting)
 - i. Challenging to look at just crude positivity as a result
 4. What does national IPP data tell us
 - a. A lot of testing going on!
 - b. Crude positivity is increasing
 5. What do national IPP data not tell us
 - a. Incidence of chlamydia and trends in prevalence
 - b. National IPP data reported in surveillance report do not account for:
 - i. Changes in screening coverage or criteria
 - ii. Changes in test technology
 - iii. Changes in clinics included and amount of data reported
 - iv. Changes in clinic mix, i.e. who is going to the clinics
 1. E.g. if start getting more adolescents, positivity might increase – but not reflecting increase of CT positivity in community, rather change in patient pop
 - c. Additional data analyses and sources are needed
 - i. Regional and local analyses
 - ii. Consistent screening criteria and reporting practices
 - iii. Representative of the general population
 1. Look to NHANES
 - a. National probability survey
 - b. Primarily around nutrition and physical activity
 - c. Also includes urine-based NAAT test for CT and GC
 - d. Random sample across U.S.
 - e. Results: CT prevalence has decreased between 1999-2008 (among men and women)
 - f. Results: CT prevalence is pretty flat
 2. Limitations of NHANES
 - a. Low prevalence plus small sample sizes = unstable estimates
 - b. Data only available at national level
 - c. Data not timely

6. Catherine's Dissertation – CT Positivity trends among women aged 15-24 in FP clinics 2004-2008
 - a. To account for unmeasured factors, analyzed at the clinic level
 - b. Regression analysis
 - c. Results – CT positivity was flat (i.e. no change)
 - d. Limitation: unable to account for changes within clinics over time
 - i. Can't see these changes at national level
- c. What's going on with CT nationally?
 - i. Case reports increasing
 - ii. Positivity and prevalence estimates suggest stable or decreasing morbidity
 - iii. Multiple data sources used to supplement traditional case report surveillance
 - iv. Opportunities to reconsider how to else to measure CT morbidity
- d. With the national IPP data
 - i. CDC no longer collecting after 2011
 - ii. Each state will determine what is useful for them. What do you need to interpret trends locally?
 - iii. Really trying to make the data useful on a local level
- e. Rescreening and re-infection regionally
 - i. Highlights for three presentations at the 2012 national STD prevention conference
 1. Region II, Region V, Region X
 - ii. Region II
 1. Objective: to describe annual re-screening rates and repeat positivity among patients attending facilities participating in the region
 2. Extracted limited variables from electronic lab data, each project area came up with unique ID, calendar years 2007-2009
 3. Outcome measures: rescreening rate, repeat positivity
 4. Results
 - a. 14% of males rescreened at 1-6 months and 22% of females
 - b. Among males, 25% reinvested, 16% among females
 - c. Positivity highest among those in juvenile detention centers
 - iii. Region V
 1. Objective: identify rescreening/reinfection rates client demographics and facility type
 2. Data sources: IPP data using client name and DOB (to create unique ID) or else create their own unique ID
 3. Looked at all people diagnosed between July-Dec 2009 and followed each for 12 months
 4. Outcomes: rescreening rate (31-180 days or 31-364 days), repeat positivity (proportion who had a 2nd CT and test result in time period)
 5. Results
 - a. 26% rescreened in 31-180 days
 - b. 37% rescreened in 31-364 days
 - c. 10% reinvested in 31-364 days
 - d. Rescreen results varied by race/ethnicity
 - iv. Region X
 1. Objective: why are rescreen rates so low?
 - a. Low client return rates?

- b. Providers missing opportunities to retest?
 - 2. Data source: title X client visit record
 - 3. Outcome measures: client return rate (3-12 months post-treatment), proportion of clients returned who were not rescreened
 - 4. Results
 - a. 41% didn't return to clinic
 - b. 59% returned in 12 months
 - i. 8% less than 1 month
 - ii. 13% 1-3 months
 - iii. 18% in 3-6
 - iv. 38% in 3-12 months
 - 1. 38% not retested
 - 2. 52% rescreened at first return visit
 - 3. 10% rescreened at subsequent return visit
 - 5. Therefore, determined that about 76% were not rescreened (due to low client return rates and missed opportunities)
- f. Article: Best Practices for the Prevention and Early Detection of Repeat and Chlamydial and Gonococcal Infections: Effective Partner Treatment and Patient Retesting Strategies for Implementation in California Health care Settings
 - i. Return rate may increase with: counseling, reminder systems (e.g. text)
 - ii. Decrease missed opportunities: flag charts, expedite options, etc.
- g. Summary
 - i. Consistently low rescreening rates and high positivity among those rescreened
 - ii. When calculating rescreening and reinfection rates, consider:
 - 1. Do you have necessary data elements (e.g. unique ID)?
 - 2. What follow-up time period makes sense to use?
 - 3. Who do you include in the denominator?
 - iii. When trying to improve low res-screening rates, consider what's driving low rescreening rates (i.e. patients not coming back, providers missing screening opportunities when patients do come back)
- h. Q&A
 - i. Job Corps data
 - 1. National job training program is a residential vocational program for disadvantaged youth 16-24
 - 2. When they enter program get CT and GC screen
 - 3. Prevalence has been decreasing among this pop (when accounting for other factors)
 - 4. Good surveillance system, but we don't know how generalizable it is
 - a. Unsure whether this population is changing
 - ii. Fascinating/surprising that overall rates are decreasing
 - 1. In UK, think of case rate instead as diagnosis rate: i.e. it measures how well we're finding and diagnosing women

F. Regional Data Update (JSI)

- a. Data overview
 - i. 2006-2011 have reduced number of clinics funded by IPP (140 to 113) – only those that have reported data

- ii. VT has lowest positivity, RI has highest (among women only)
- iii. Decrease in women over 25/26 without risk factors tested
- iv. Goal: get 95% of women over 25/26 tested should have risk factors.
 - 1. ME, MA, NH have all improved
 - 2. RI has had lowest percent of women over 25/26 having risk factors VT strong at 90%
- v. In 2011, added PTO and rescreen variables to lab slip
 - 1. Positivity for rescreens is 2-3 times higher than non-rescreens
 - 2. Percent of visits that are PTO visits in 2011
 - a. Primary reason for visit is pregnancy test, there is no physical exam
 - b. Positivity rates higher among PTO in a few states, lower in a few
 - i. These data are only for women under 25/26 – i.e. those highest risk
 - ii. PTO is another opportunity for people to be reached, even if these people don't necessarily have higher positivity
 - 3. There was a learning curve in checking off the PTO and rescreen boxes on the lab slip
 - 4. The idea of the annual exam is kind of fading – all the more reason to catch people whenever they come in and not miss opportunities

DAY 2

- A. Infrastructure Updates (JSI)
 - a. Jaya is going to graduate school at UNC-Chapel Hill
 - i. Marie and Hallie will take over her role on the project
 - b. Jennifer is moving to Sacramento, CA
 - i. But she will still be involved in IPP
- B. Billing and Reimbursement (JSI)
 - a. The STDRPTAC will provide training and TA on three areas, including billing and reimbursement
 - b. It is now an expectation that clinics will need to have billing and reimbursement capacity
 - c. National assessment of billing and reimbursement capacity
 - i. Region I has a higher capacity than most of the rest of the country
 - ii. Regions were asked what kinds of technical assistance agencies need in order to initiate or expand third party billing
 - 1. Region I rated Medical coding and maintaining confidentiality higher than the nation as a whole
 - d. Region I infrastructure did regional assessment
 - i. Representation from all states
 - ii. For some states, one person or a few people responded on behalf of all sites
 - iii. Site types include labs, school-based health centers, family planning agencies, community health centers, STD clinics, and other clinics
 - iv. Results
 - 1. Most billing Medicaid (70%) and other third parties (66%)
 - a. 25-50% services billed to Medicaid

- b. 10-25% services billed to other third parties
- 2. Cannot Medicaid by site type:
 - a. Small number of FP and CHC and school-based
 - b. Third of labs
 - c. More of STD, other
- 3. Connecticut STD clinics cannot bill Medicaid
- 4. Cannot bill other third parties
 - a. RI and VT can bill other third parties
- 5. Do not have staff capacity to bill
 - a. FP agencies and CHCs have most capacity
 - b. Labs and STD clinics have work to do on billing capacity
- 6. Medical billing process
 - a. Insurance verification, patient demographics entry, etc.
- 7. Barriers to contracting
 - a. Some companies have refused to contract with FP
 - b. Some want patients to get FP and STD at the primary care
 - c. If MD has no hospital admitting privileges, may be refused
 - d. Some clinics lacking capacity
 - e. Many haven't tried
- 8. Barriers to billing Medicaid
 - a. Capacity and perceived expense of implementation
 - b. Rates differed greatly
 - c. Time spent on claims and reimbursement
 - d. Reimbursement goes directly into state general funds
 - e. Dual coverage clients
 - f. Other barriers?
 - i. Very specific coding requirements
 - ii. Clinicians need to get on board with committing time, resources, etc. to billing, and relationships with finance
 - iii. Credentialing
 - iv. Doing all these things doesn't guarantee financial viability
 - 1. Shifting to a situation where you put effort into billing out without assurance that you'll get necessary funding
 - v. QA of coding and charts will be a big task
 - vi. Some best practices are doing education and partner services – but can't bill for these (can only bill for patient face-to-face services)
 - 1. There need to be funds for these best practices
 - vii. Medicaid can audit sites and request a lot of records – big drain on resources
 - g. Will turn this into a written report that will inform STDRPTAC
- 9. Barriers to billing other third party payers
 - a. Many the same as Medicaid
 - b. Unclear what is covered and how to code to get covered
 - c. Even if pre-certified, not guaranteed that you'll get reimbursed

- d. Site not approved as billable site
- e. Time prohibitive
- f. Some third party insurers want to do site visits
- 10. Training and TA needs
 - a. Billing
 - i. Software/capacity
 - ii. Rate setting
 - iii. Electronic records
 - iv. Everything
 - b. Coding
 - i. Complicated and confusing
 - ii. Software
 - iii. Hardware
- 11. Other comments
 - a. May not want to use insurance for minors
 - b. EOB issue
 - i. Medicaid doesn't send out EOBs, but private insurance does
 - ii. Under ACA, no co-pays for A-rated services (preventive services, CT screening falls under this category)
- e. More to come from the STDRHPTTAC

C. IPP Reflections

- a. Working in the lab can be an isolating experience, so it's wonderful to come to the meetings and talk with counterparts in other states – can share your work and learn from others
 - i. Laboratorians have gotten a lot out of it and learned a lot
 - ii. There was an emergency at the NH public health lab – their pipes froze and the building flooded, so they had to cease operations for weeks
 - 1. Carol Loring called other Region I IPP labs to help
 - 2. ME and MA labs took on their CT and GC testing
 - 3. This is attributable to the professional relationships developed through IPP
 - 4. These collaborations should and must continue
- b. These meetings used to be unpleasant at the beginning of IPP – we have grown so much
 - i. Understand so much more about family planning and the lab
 - ii. Know other representatives in the state better as a result
 - iii. Can learn about other project areas
 - iv. There are always helpful data and presentations
 - v. The meetings have provided great on-site training
 - vi. Will miss wine and cheese!
 - vii. Thanks for providing data
- c. The first IPP meeting I attended, learned what I was doing wrong
 - i. Was also able to talk to other STD Directors
 - ii. NH is a lot more integrated now than it was – communication across project areas has improved a lot
 - iii. A lot of great communication across states
 - iv. JSI has been great
- d. There has always been great JSI leadership over the many years and different staff
- e. Has been great for CDC and other guest speakers to attend meetings

- f. Data is not my favorite, but IPP meetings have presented usable and easy to understand data
- g. Infrastructure comments
 - i. This is a great training ground – learn about how STDs, family planning and lab works
 - ii. We hope we'll all be here again next year!
 - iii. We have enjoyed and appreciate working with you