Region I IPP June Meeting
June 4, 2012

# Screening & Treatment/Data Subcommittee Meeting

Participants
Lisa Marvinsmith (CT)
Heidi Jenkins (CT)
Marcy Moyel (MA)
Roberta Moss (MA)
Elizabeth Torrant (MA)
Lynda Sampson (MA)
Bryanne Wainford (MA)
Christina Lombardo (MA)
Laura Smock (MA)
Brenda Cole (MA)
Evelyn Kieltyka (ME)
Sarah Elie- Bennett (ME)
Michelle Ricco (NH)
Lindsay Pierce (NH)
Barbara McNeilly (RI)
Brittany Isabell (RI)
Sarah McGinnis (VT)
Daniel Daltry (VT)

## A. Future of IPP

a. JSI will no longer provide Lab slips through the infrastructure. The question is what will states do without that support?
   i. NH planned to do away with lab slips. However if IPP ends then won't be able to continue any lab work. Mirrored some performance measures with family planning. Because this is a requirement, looking at a systems approach for all family planning clinics and looking to invest in the lab so that clinics can continue to submit to state lab. Keep the lab slips the way they are (good reminder for providers over eligibility)
   ii. RI: if we can find resource for the actual data entry will continue to use lab slips and access database. A lab extract would not have the risk factors or race and ethnicity.
   iii. States have appreciated the site specific report so if we go without the prevalence monitoring database won't be supplying that anymore.
   iv. How to handle the data piece going forward: from a data standpoint less dependent on IPP especially with EHRs. Those with EHRs will still have access to the data they need (and it will be instantaneous).
   v. Concern about after 2013. There will be a lot more pressure to do your own surveillance.
   vi. People will not get tested unless we pay for it and morbidity go up.

vii. Need to document the rise in positivity: if you stop screening, chlamydia rates will go down.
    1. Case rates would go down
    2. Screening rates would also go down
viii. MA says that 40% of clients are not covered at time of service at FP clinics
    1. With insurance plans there is credential process so sometimes practitioners can't be part of an insurance plan.
    2. Also have many undocumented individuals

**B. Statement on CSPS from the region**

a. JSI will lead the development of the statement

b. There should be some security built in for IPP in changing health care environment
    i. Monitoring trends in morbidity (have a target of where this should be)
        1. VT usually has about 1200 in chlamydia but if they go down to 856. This decrease is that not the right people are getting screened again.
        2. Worse case 2000 cases of chlamydia which would be an outbreak in VT
c. Some funding allocated for transition (not for screening)
d. Lab needs to go through the process for billing and reimbursement but think there will be supported
e. Could give the money for staff and could have them try to secure state funds for test kits
f. All public health labs should still be doing cultures even if we have no way to pay for them
g. Recommendation: CSPS to have vague wording about using funding for screening: The funding would go to family planning in transition to the ACA. May want a percentage of dollars, may have to decrease but it at least gives everyone notice of what they have to do.
h. Parity with HIV programs is important - didn't come to a complete stop but gave time to figure out how to sustain these programs with less funding.
    i. What about EOB- explanation of benefits? CT doesn't have to worry about that. But the rest of the region has to be concerned.
        1. In NH parents don't have access to their children's records online (after age 12)
    b. Work force and credentialing issue
        1. Certain individuals do not have traditional credentials so they are ineligible to join BCBS
        2. An issue of the work force but also looking a waiver
        3. This varies area to area and IPA to IPA etc.
        4. If you can credential your agency, (that varies state to state)
            a. What you are billing as a clinic or private practice etc.
        5. When does in-house vs. out- house billing make financial sense
    c. What data could be used to demonstrate the anticipated consequences:
        1. Lost screening opportunities due to cuts (but people are going to be insured)
        2. How long did it take for MA to ramp up their insurance rate
        3. Has the pool of uninsured people decreased in MA?
        4. Still need to provide a safety net
        5. There is a waiver for insurance
        6. There are people who fall off

7. Other side: even though people have more options are the providers really ready to provide these services?
8. Is there an appreciation for the argument that PCP don't talk about sexual health because they do not get the training they need?
9. In MA, ER use didn't change (people who need something immediately will probably still not be able to see a PCP)
10. Having a regional statement will not preclude any one from sending their own statements