Region I IPP June Meeting
June 5, 2012

STD Meeting

Participants
Heidi Jenkins (CT)
Laura Smock (MA)
Brenda Cole (MA)
Sarah Elie- Bennett (ME)
Lindsay Pierce (NH)
Brittany Isabell (RI)
Daniel Daltry (VT)

A. Prevalence monitoring-Plans for Data Collection

a. Is the IPP lab slip helpful or are there other general lab slips
    i. Non IPP clinics use a simpler lab slip
    ii. IPP slip is easier to figure who the test is billed to
b. NH is still planning on using their LIMS database but still need to discuss
    i. Biggest concern is paying for lab slips but that came into the carryover budget
    ii. Could ask clinics to copy their own lab slips
    iii. Will monitor positivity through the whole site self-report
c. MA will probably keep the lab slip but won't be analyzing the risk factors because they will not be using the access database. They can get a lot of the information out of the LIMS
d. ME is leaning towards keeping things the same until the end of funding
e. CT is going to stop using the lab slips and go to state lab slips and all planned parenthood sites or other IPP eligible will be labeled as IPP (just for consistency purposes)
    i. There would be a lab coding for planned parenthood that they will be billed for
        1. IPP over the age of 25 will be moved to Planned Parenthood and they will be billed
        2. Sites with labs will have a state clinic account
    ii. STD MIS has race and ethnicity for who is positive
        1. Screening coverage from planned parenthood
    iii. PTO could be an issue depending on whether they capture that in the state database
        1. Could be pulled from EMR and it won't be just IPP people
    iv. See this as getting more information
        1. Planned Parenthood is willing to share the data

B. How do you plan on using the data you will collect

a. CT sees it as a way to look at what sites they should continue to support (such as their positivity rate).
    1. Using positivity as a way to target funding
    2. Planned Parenthood is sharing a lot of information and feel that they are very successful.

b. NH doesn't have a picture of screening from any other source.
    1. It's the only place where we are getting this data.
    2. If the site positivity was much higher than IPP positivity, it allows us to know there is a high level of infection there that without that information we would not have an idea of positivity rate.
c. ME has added back family planning sites that had been cut after looking at IPP positivity only.
d. IPP is the pool of data to get prevalence (positives and negatives)

C. How to notify the sites about the changes to IPP

a. What is safety net—no definition yet
b. Want to give them as much time as possible to be prepared for these changes
    i. March 1st the FOA will be out and could use that
    ii. Could use the language from Dr. Bolan's slides
    iii. Can always use the language in CSPS

D. Other Updates

a. MA would like to know if there is an increase of MSM population coming to family planning clinics?
    i. In MA, there has been an increase in syphilis cases
    ii. There are 3 STD clinics in ME but find they are getting calls from family planning clinics
b. Can any family planning clinics do rectal CT/GC speciman?
    i. ME can't but MA accepts pharyngeal and rectal specimens.
    ii. CT is not
    iii. NH found that he GC cultures were coming from STD clincs so have been working with a few sites with very high risk patients to get cultures from.
        1. Were able to get HIV prevention funding to a high risk, resistant individual.
    iv. Trying to get an increase in extragenital culture in MSM with insurance to test with private labs (Quest etc)
c. Description of projects that receive HIV prevention grants
    i. CT: hired an internet person to put messages to all the website
        1. Also included hiring a DIS to track individuals with high viral loads but that didn't get funded

E. Working together as a region

a. Seems like we are all approaching the data management slightly differently but would still be great to work together over the next year and a half
b. Need guidance on the upcoming FOA
    i. Definitions with examples would be helpful.
    ii. TB guidance was good because there are very specific guidelines about what minimally must be addressed.
    iii. Have a training where CDC defines, and gives good examples
    iv. Suggest that they make the FOA simpler and with less to measure
    v. Epidemiologist
        1. Its FTE will be up to the state - not all states need a full FTE

vi. For upcoming FOA: be training by region. If possible, make TA available upon request for additional assistance

F. Data Systems and collaboration with HIV

a. NH us working on an infectious disease manager to address recapture
b. SSuN (STD surveillance network) is going to remain.
    i. CDC is looking at SSUN as a good mechanism to strengthen surveillance.
    ii. CT is interviewing in Hartford and New Haven and geocoded and found two census tracks with the highest case numbers and now doing interviews in that zip code
        1. Numbers are going up in one zip code, its very interesting
c. MA and ME are in the process in going to Maven PRISM. Anticipate that it will change everything with the DIS. Partner services for HIV and STD will go in there.
    i. Addressing who can access the data
    ii. PRISM is free but have to pay for maintenance
    iii. Support for MIS is going away but not sure when
        1. CT is going to be a guinea pig site for 5.0
        2. NH will be going on 5.0
    iv. NH is using NEDS for other communicable diseases.
        1. TB is using an excel spreadsheet and an older database so will be getting NEDS for TB.
    v. MA is trying to build a bridge between two programs so DIS will start interviewing people with just HIV or STDS
    vi. MA is trying to integrate data sharing
    vii. ME , CT and NH have DIS who address both
    viii. RI is focusing on working security and confidentiality but are moving towards being the same group.
        1. STD MIS will allow partner services go in there
    ix. In most states DIS are entering their own data except for ME but they will start to be able to do that.
d. Work with HIV and STD
    i. CT: Interviews of co infections are put in database.
        1. Getting between 20-30% newly diagnosed HIV positive individuals through testing.
    ii. NH is confirming linkage to care now
        1. Do more of a case management approach
        2. HIV is paying for TB screening and paying for newly active TB cases that have not had an HIV test done
    iii. ME: think part of HIV funded services goes into counseling and testing training for providers.