Main Meeting Minutes
Region I IPP AB Meeting
November 9, 2011

Participants

Connecticut
- Susan Lane
- Gary Budnick
- Heidi Jenkins

Massachusetts
- Marcy Moyel
- Arthur Kazianis
- Roberta Moss
- Laura Smock
- Christina Lombardo
- Elizabeth Torrant
- Hillary Johnson
- Tracy Stiles
- Linda Han

Maine
- Jemelie Bessette
- Evelyn Kieltyka
- Sarah Elie-Bennett

New Hampshire
- Lindsay Pierce
- Carol Loring

Rhode Island
- Robert Ireland
- Barbara McNeilly
- Michael Gosciminski

Vermont
- Rebecca Lavasseur
- Eunice Froeliger
- Daniel Daltry

JSI
- Andee Krasner
- Jennifer Kawatu
- Jaya Mathur
- Marie Kaziunas

CDC/Public Health Representatives
- Steven Shapiro
- Kathy Desilets

A. Welcome & Introductions (Jennifer Kawatu)
    a. There is no speaker lined up for today, but we will have a speaker by webinar in the next few months – Infrastructure is open to suggestions, please submit any ideas

B. CDC Update (Steve Shapiro)
    a. CSPS 2012 (cooperative agreement)
        i. Expect to be funded at 2011 levels as of now
        ii. Expect a new continuing resolution at the end of this week
        iii. Revised budgets are due November 10, 2011
        iv. The intent was to create a streamlined application
        v. Performance measures are no longer required after this year
            1. States will still need to report PMs through March 31, 2012 – beyond that, it is up to states
            2. Steve recommends continuing to look at timeliness of treatment measures
        vi. Additional guidance
            1. Every project area is required to set aside some of the travel budget to attend the national STD conference in Minneapolis in March
                a. If this money is set aside, grantees must send a representative
            2. There is new language strengthening the requirement that representatives attend IPP meetings
            3. If the proposed supplemental budget makes sense and activities proposed are appropriate, will probably get this money
    b. DSTDP Update
        i. Personnel changes
            1. Katherine Satterwhite was an epidemiologist in the Epidemiology and Surveillance branch has moved on but is still involved in IPP
                a. Her CDC email address still works
                b. Her replacement is Lizzie Torrone
        ii. Division realignment
            1. Dr. Bolanis creating a new division structure (see org chart in Steve's presentation)
            2. The policy office is gaining about 7 positions
            3. The division is going from 6 branches to 7 branches
                a. Program Development & Quality Improvement Branch
                    i. Includes a program support group, i.e. project officers and program coordinators
                        1. If anyone has an epidemiology question, they should contact their PO
                        2. Program coordinators will not be so intimately involved with state activities – POs will not contact states, states must contact POs
                b. The budget will be managed by the Management & Operations office
                c. Laboratory Reference & Research Branch
                d. Surveillance & Data Management Branch
                e. Epidemiology & Statistics Branch
                f. Health Services Research & Evaluation Branch
                g. Social and Behavioral Research & Evaluation Branch
            4. Programs will have to at least address PCSI (i.e. service integration at the client level) in their applications
            5. POs and program coordinators will have lateral re-assignments

6. The realignment should be in place by the end of January

iii.

iv. Steve is uncertain what his new position will be

v. States may decide that they don't need prevalence monitoring data, but there will still be requirements for the grant
    1. E.g., a state may feel it can do this without prevalence monitoring data
    2. CDC is operationalizing the idea that state and local health departments need to take responsibility for their decisions
    3. All state STD programs should have access to an epidemiologist (at least part-time)
        a. The NCSD board meets with Dr. Bolan monthly to discuss the new grant
        b. NCSD has been communicating with Dr. Bolan – she is trying to be responsive to the field

c. Publications
    i. NG with reduced susceptibility to Azithromycin in San Diego
    ii. DCL-Azithromycin Resistance in Hawaii
    iii. 2010 STD surveillance report
        1. There will be a webinar about it

d. Current Activities
    i. PCSI
    ii. Data security and confidentiality guidelines
    iii. Antibiotic-resistant GC outbreak response plan

e. NCHHSTP Confidentiality and Security Guidelines
    i. This is a collaborative effort across divisions, including TB, viral hepatitis, HIV
    ii. This should not be used to prevent data sharing
    iii. These guidelines should be published by the end of the year and will be in all funding announcements once published
    iv. 10 guiding principles
        1. Collection and acquisition
        2. Use
        3. Release and sharing
        4. Storage
    v. There are minimum standards to ensure physical and electronic security, C&S training, and establishing of MOA/MOU
        1. There is a required self-assessment on all standards with compliance plans

f. National Action Plan for the Prevention, Detection, and Management of Infertility (Division of Reproductive Health)
    i. This plan doesn't spend a lot of time on infectious causes of infertility, rather mostly on e.g., men with low sperm counts, women whose uteri are unable to support implantation
    ii. This plan will be released in the near future
    iii. Infrastructure will post this plan to the website

g. "Working in a transformed health care system"
    i. Key issues
        1. Affordable care act and performance improvement
        2. National HIV/AIDS strategy
        3. Agency winnable battles, e.g., HIV and teen pregnancy prevention
    ii. The future of IPP
        1. This was an Infrastructure-driven evaluation

2. The study will provide recommendations for the future of IPP in the context of the Affordable Care Act
3. The final report is due to CDC on November 15, 2011 (spearheaded by JSI Denver, which is the Region VIII IPP Infrastructure)
4. Impact on STD prevention
    a. Assurance, policy development, assessment and accountability, and safety net coverage (though it is unclear what the definition of safety coverage is)

h. Antibiotic-resistant GC outbreak response plan
    i. GC epidemiology
        1. GC rates by race-ethnicity
            a. GC is the highest disparity ratio among health conditions (not just infections)
        2. GC rates by county
            a. GC is still concentrated in the southern and east coast counties
            b. Recent outbreaks include: Alaska in 2009, the Rosebud reservation in South Dakota, and Alberquerque and Gallop, New Mexico
                i. Most of these outbreaks have started to dissipate
    ii. Trends in cephalosporin susceptibility: international trends
        1. 2000 – possible cefdinir treatment failure in man with urethritis (MIC=1, which is very high)
        2. 2001 – 2 cases with decreased cefixime susceptibility (MIC=.5)
        3. 2002 – in Japan, 30% of isolates with decreased cefixime susceptibility (MIC >=.5)
        4. 2003 – 4 possible GC cefixime treatment failures in MSW
        5. 2008 – 2% of isolates with ceftriaxone MICs >=.6
        6. 2009 – Increases in ceftriaxone MICs in Europe; In Japan, pharyngeal isolate from CSW with ceftriaxone MIC=2 (subject of recent media "superbug" coverage)
        7. 2010 – ~30% of isolates in China had elevated ceftriaxone MICs; 2 cefixime treatment failures in Europe; pharyngeal treatment failure in Europe; and 2 possible cefixime treatment failures in Europe
        8. 2011 – cefixime treatment failure in England
        9. Question – has there been ceftriaxone failure in anything but oral?
            a. No
    iii. Trends: US
        1. Gonoccocal Isolate Surveillance Project (GISP)
            a. US sentinel surveillance
            b. GISP monitors trends in NG antibiotic susceptibility
            c. GISP collects data from 26-29 STD clinic sites
            d. Urethral NG isolates are obtained from the first 25 men per site each month
            e. Susceptibility testing is conducted by 4-5 regional labs
            f. Confirmatory testing is conducted by CDC
            g. Minimum inhibitory concentrations (MICs) by agar dilution
            h. Ceftriaxone should be used to treat pharyngeal infections (cefixime is not so effective in pharyngeal infections)
            i. GISP sites and regional labs
                i. Labs are in New York City, Atlanta, Birmingham, and Seattle
            j. Emergence of FQ resistance: Hawaii

i. It is thoughts that cephalosporins will follow the same pattern of resistance as fluoroquinalones did
ii. It is expected that resistance will occur at a more rapid pace
iii. The bug can develop resistance quickly
iv. When isolates reach 5% resistance, that is when CDC recommends to stop use

k. Proportion of isolates with elevated MICs to Cefixime (>=.25 micrograms/ml)
i. There was a huge jump from 2006-2009 to 2010
ii. By region, there is the same pattern as FQs (starting in the West)
iii. We are seeing resistance in MSM first

2. Moving forward
a. There are no new drugs in the pipeline
b. CDC is partnering with NIH on clinical trials now
c. It will be more expensive to treat GC
d. There has not been a lot of media coverage of GC resistance
3. Challenges
a. GISP is not timely – it is good for monitoring trends over time, but not when an outbreak occurs
b. Lack of alternative treatment options
c. Low awareness of problem
4. National response planning
a. Activities
i. Surveillance
ii. Raise awareness
iii. Enhance USG and international collaboration
iv. Promote identification of new treatments
v. US cephalosporin-resistance GC response plan
1. Continuing to report GISP
2. Clinician reporting of treatment failures
3. Lab reporting of resistance isolates
4. Consider enhanced local surveillance
a. States should try to investigate every positive GC
b. Should we restart the process of test-of-cures?
5. Working case definition – suspected cases
a. Clinical criteria
i. Lab confirmed GC infection
ii. Patient received recommended cephalosporin
iii. Follow-up test is positive
iv. No sexual contact after treatment
b. Laboratory criteria
i. Cefixime MIC ≥ 0.25 µg/ml
ii. Ceftriaxone MIC ≥ 0.125 µg/ml
6. Working case definition – probable cases
a. Clinical criteria
i. Lab confirmed GC infection
ii. Patient received recommended cephalosporin
iii. Follow-up test is positive

iv. No sexual contact after treatment
v. Cefixime MIC ≥ 0.25
vi. Ceftriaxone MIC ≥ 0.125

b. Laboratory criteria
i. Cefixime MIC ≥ 0.5 µg/ml
ii. Ceftriaxone MIC ≥ 0.25 µg/ml

7. Treatment of initial cases
a. Cefixime treatment failure
i. Ceftriaxone 250 mg IM & Azithromycin 2 gm
ii. Report to health department & CDC
b. Ceftriaxone treatment failure
i. Report to health department & CDC
ii. Infectious disease consultation
c. Obtain specimen for culture/AST (before re-treatment)
d. Test-of-cure
e. Ensure partner treatment

C. Future of IPP (Jennifer Kawatu)
a. The purpose of the "Future of IPP" is to provide an assessment of IPP today and what it will look like in the changing health care environment
b. This is a compilation of national and regional assessments
c. Process
i. There were three surveys: Lab, FP and STD state partners, and clinic capacity
1. Most Region I findings were aligned with national findings
2. Findings: see slides
3. Billing was a strength in Region I
4. Coding was the highest need determined by the capacity surveys in Region I
5. Discussion:
a. Training clinicians to code correctly is the issue
b. Safety net providers now in many clinical positions didn't have to do this for years and coding requirements change over time
ii. Key Informant Interviews (Qualitative Findings)
1. Safety net funds as necessary after ACA for multitude of reasons
2. Future role of IPP
a. Training and education
b. Data and data systems
c. Technical assistance
iii. Summary
1. Concerns
a. Over-saturation
b. Third-party billing capacity
c. Administrative burden
2. Strengths
a. People coming together/connections between states
b. IPP directs states on what is important in terms of focus
c. Standardization
d. Information to provider community
e. Best practices
f. Connection to the federal level
g. Material development
iv. Next steps

1. The national report will be submitted to CDC on 11/15
2. Steve will summarize the findings and circulate this to states and other key parties

v. Response

1. Would hate to see IPP become an administrative entity
2. With the changing environment, we could use IPP as a resource to help us work together as a whole and not just as a funding source
3. Some people are taken aback at the idea of screening males since males are not a part of evidence-based research
    a. This is surprising since we have made such strides as a data-driven project
    b. This is something we shouldn't lose going forward
4. Once there is heavy female screening after ACA due to the HEDIS measure, we should look to more comprehensive screening of males
5. Even once there is less of a need for free tests (due to insurance) there will still be a need for free screening.
6. Having the tests available is where we get the buy in from the clinicians
7. Challenges related to different requirements of different states – in the future, it may be worthwhile to standardize across clinics, labs, etc. in small states
8. In NH we only collect data for IPP tests, which is an issue when it comes to looking at positivity
    a. Looking at site positivity, we aren't really getting full picture of what is going on, which is hindering our ability to understand the scope of the issue
    b. In terms of private providers, we are being forced to go into that direction, so going forward education and referrals are important

D. State Report Back

a. Connecticut

i. How are budget cuts impacting IPP in your states?

1. Conn didn't really have funding cuts
2. There have been personnel cuts; they may experience a reorganization
    a. Lab is down personnel significantly and they are moving into a new space

ii. What are you doing to deal with resource limitations?

1. More funding related to HIV and more priorities aligned with HIV
2. Nothing with CT, limited with GC; doing work with syphilis and PCSI
3. STD is not on the radar screen, we aren't high on the priority list
4. In the lab, trying to make do with one person (versus 3-4 people), though improved technology is helping

iii. What, if any, news do you have on the implementation of ACA in your state?

1. The TB program is implementing OBRA (Medicaid Program)
2. The state gets reimbursed 50%
3. Local health departments are going to have to register with Medicaid to become a payor – this is a good first step with ACA
4. Groups are talking about who they have to partner with on the community level, not privy to conversations on the state level
5. Family planning is getting a spot on the state level (hopefully in January or soon after) that will cover uninsured up to 250% of poverty

b. Rhode Island

i. How are budget cuts impacting IPP in your states?
    1. STD funding was cut in June (new fiscal year)
    2. The STD clinic was closed in July, which saved $250,000
    3. There is a big deficit
    4. Other agencies stepped up to take on patients
    5. The lab is not replacing people, and the lab is in the same facilities
ii. What are you doing to deal with resource limitations?
    1. In the next year, we are going to do an education plan to providers in RI including treatment guidelines, recommendations etc.
    2. Trying to have an article in the journal and a presence at conferences (Brown's HIV Program)
    3. Next year there will be a focus on education
    4. The lab is trying to automate what they have to keep the same level of quality with reduced staff
iii. What, if any, news do you have on the implementation of ACA in your state?
    1. Primary care has been a new focus for RI
    2. Mike Gosciminski will be replaced by another individual in the DOH

c. Massachusetts
    i. How are budget cuts impacting IPP in your states?
        1. Funding cuts from other sources have caused closing of IPP clinics
        2. Family Planning won't be receiving OHA funds for HIV tests
        3. HIV dollars are being realigned ; MA has lost half of its funding related to HIV that has been redistributed to other states
    ii. What are you doing to deal with resource limitations?
        1. Sharing staff between clinics
        2. Using patient navigator (one clinic) paid for by a grant to help patients without insurance obtain insurance. Not sure what will be done after the grant ends.
    iii. What, if any, news do you have on the implementation of ACA in your state?
        1. FP clinics are trying to align themselves better with CHCs
        2. Also, trying to organize, discuss and prepare in the state for ACA
        3. Maybe we should have a CHC representative come and discuss what they've done at the next IPP meeting (e.g., Clare Coleman from NFPHRA)
        4. GW University and Guttmacher Report discusses how HCs and CDC should collaborate to prepare for ACA

d. New Hampshire
    i. How are budget cuts impacting IPP in your states?
        1. There have been major cuts across the Department Of Health and Family Services
        2. The entire STD budget was cut and all STD clinics were closed
        3. Integrated CHCs continue to provide FP services
        4. Some CHCs offer risk-based HIV services
        5. Lost half of the HIV budget, which will create changes
        6. Lost DIS, so now there is one for the entire state
    ii. What are you doing to deal with resource limitations?
        1. Working to make a statewide referral system (however cost is borne by the patient once they are linked to a site)
        2. There are now no funds for testing (state funds that supplemented IPP funds), which will cause a drastic change in how we handle treatment and testing for IPP
        3. Changed DIS follow-up criteria, changed HIV screening criteria and going through re-organization

a. TB and disease investigation is going to join the division doing STD testing
b. This reorganization started November 1, 2011 and will continue to unfold

4. The state is waiting to see if it will receive federal funding for HIV
5. This is a small state, with low morbidity
6. The state has been good at working together and with the New England team

iii. What, if any, news do you have on the implementation of ACA in your state?
1. This information as not come to our level yet
2. Right now we are dealing with day to day and so it has not come to dealing with this yet
3. NH will become part of federal system, because they did not accept funding to create a state health insurance exchange
4. Planned Parenthood is now directly funded by Title X

e. Vermont
i. How are budget cuts impacting IPP in your states?
1. The budget is all federal (i.e. Vermont has no state dollars in STD)
2. When someone retires, the position is eliminated (i.e. there no DIS)
3. Holding steady with testing and treatment (Planned Parenthood is the STD clinic)
4. Comprehensive services are at stake

ii. What, if any, news do you have on the implementation of ACA in your state?
1. The governor in VT wants to move forward with universal health care & single payer system
2. The commissioner is working toward that goal, but there is a lot of red tape and more time is needed
3. Already discussing needs with Medicaid about coverage – trying to be proactive about conversations

f. Maine
i. How are budget cuts impacting IPP in your states?
1. We have a budget and we don't think it will be impacting IPP

ii. What are you doing to deal with resource limitations?
1. We are okay in this department

iii. What, if any, news do you have on the implementation of ACA in your state?
1. There is no news on this

E. PTO Regional Report (Andee Krasner)
a. Background
i. IPP made it a national objective of each of the ten regional IPP infrastructure projects to disseminate a regional epidemiologic profile of pregnancy-testing only (PTO) clients seen in prevalence monitoring clinics

b. Objectives
i. Survey of providers in Region I to look at their PTO screening practices
1. Primary reason for visit is pregnancy test (this indicator is not used at the clinical level, but used at the Infrastructure level)
2. Provide baseline CT screening rates among PTO women

c. Methodology
i. 1st data set: provider survey
1. N=295 from all six states
2. Respondents from FP clinics, CHCs, STD clinics, other
3. 20% (n=59) did not answer PTO questions

ii. 2nd data set: region I family planning data system (where title X clinics report data, commonly called FPAR data)
    1. Received a limited data set
    2. Data includes FP clinics, school-based clinics, and DYS

d. Definition of PTO
    i. General definition – the primary reason for visit is pregnancy test
    ii. Variable definition – a woman did not receive a physical exam, injection or STD screening (other than CT, GC or HIV) at visit

e. Age categories for analysis – used 24 and younger for the age cutoff in all states to reflect the highest screening rates

f. Limitations
    i. Constructed the PTO variable based on visit type response options (we don't actually know the primary intention of visit)
    ii. No national CT screening rates among PTO visit to compare to (use pelvic exam screening rates as a benchmark)
    iii. No CT positivity rates in Title X FP data set – rely on published literature to suggest that positivity in PTO visits supports screening (4.7% - 13.7%)

g. Results
    i. Provider survey data
        1. PTO visits feasible because of NAAT testing (capacity to do urine-based or self-collected vaginal swab)
        2. Provider practice
            a. PTO visits are less than 20% of visits
            b. Some variability in clinic practice (some screen walk-ins, some not)
        3. Provider attitude
            a. Interest in increasing screening at PTO visits in region
    ii. FPAR data
        1. CT screening rates among PTO – increasing, mostly among teenagers
    iii. PTO screening increasing over last 5 years
    iv. CT screening rates among PTO visits by state – differentiation of baseline data
    v. Comparison of CT screening in PTO and pelvic exam visits
        1. In all states, CT screening among pelvic exams more common than among PTO
    vi. No national screening guidelinesre: PTO
    vii. Positivity rates support CT screening in PTO visits
        1. Positivity in PTO visits has been shown to be 4-13% in the literature
        2. PTO positivity of Q1/Q2 region I: 5.1%
    viii. % PTO visits in FP clinics, Q1/Q2
        1. PTO was checked on the IPP lab slip
    ix. % positive among PTO/non-PTO visits in FP clinics, Q1/Q2
        1. ME had highest positivity for PTO
        2. RI positivity highest in general population than among PTO
    x. How to increase CT screening in PTO visits?
        1. Provider and staff education about state IPP CT screening guidelines and CT positivity among PTO visits
        2. Establish standing orders, written policies and protocols that assume CT screening among PTO
    xi. Conclusions
        1. Widespread commitment to evidence-based practice in Region I
        2. CT positivity supports increased screening in PTO visits

3. Although not widely practiced in 2009, evidence suggests CT screening among PTO on the rise (steadily since 2005)
4. Commitment from Region I AB to monitor PTO visits (lab slip changes)

xii. Moving forward
1. Do AB members want to validate the PTO variable?
2. Do AB members think clinicians understand the definition of PTO?
    a. People sometimes mark off PTO when the client is already known to be pregnant

xiii. Other comments
1. Non-clinicians in some clinics perform pregnancy test – have to opt out of CT screen
2. PPNNE doing big standardization project – hopefully will see an increase in testing at any given visit
    a. An opt-out process
    b. Changing in all PPNNE states
    c. IPP lab slip is part of training re: filling it out, what boxes to check
    d. Just finished the training
3. In Connecticut there could possibly a CT reporting issue, because the state's positivity did not drop so precipitously in actuality
    a. Conn started a PTO project this summer
4. Health Quarters/MA also started a PTO project

xiv. Infrastructure can do another webinar on the form, why to do PTO, etc. if AB members think it is helpful

xv. Infrastructure could stratify by 15-19 and 20-24, though numbers are low

F. AI/AN Epi Profile in Region I (Jennifer Kawatu)
a. National objective
    i. Identify barriers to care
    ii. Identify how this population accesses STI screening
b. Methodology
    i. Worked with an epidemiologist who has experience working with AI/AN
    ii. When we say Northeast, we mean Region I
c. Overview
    i. AI/AN make up less than 1% of population in Region I (~.3%)
    ii. Nationally, more than 560 federally recognized tribes nationally
        1. Many others with state or no official recognition
        2. In the Region, 9 Federally recognized tribes
    iii. Diverse population
d. Socioeconomics in Region I
    i. AI/AN more likely than whites to:
        1. Live in poverty
        2. Have lower median family incomes
        3. Have fewer years of education
        4. Be younger
    ii. Connecticut is the exception – AI/AN tend to be better off than the general population due to casinos
e. History
    i. AI/AN population has a distinct history with the federal government
    ii. Snyder Act of 1921 led to development of Indian Health Service (IHS)
        1. IHS serves almost 2 million members of the federally recognized tribes
            a. IHS direct care

b. Tribally managed services
c. Tribal services
d. Urban Indian health programs

f. Qualitative data
    i. Contracted with medical anthropologist with extensive experience working with native population in Northeast
    ii. Cross-regional messages from KIIs
        1. Transportation challenges for rural and youth populations
        2. Fears of breached confidentiality may affect utilization choices
        3. Concerns of perceived illness connected to stigma, socio-cultural prejudice, and racism may incline individuals to not identify as natives among non-natives
        4. Concerns about identity may alter the use of non-native STD services
        5. Appropriate messaging must be culturally relevant and competent
            a. Messengers gender and tribal specific
        6. Southern New England communities may have greater access to education through smart phones and internet technologies
        7. Race/ethnicity data collection – should be client-identified
        8. Messages need to normalize and de-stigmatize STD prevention and screening guidelines

g. Other comments
    i. There are two tribes in MA
        1. Laura tried contacting them, but didn't hear back – unsure how much to push
        2. Infrastructure has contact people for MA tribes (though it was difficult making contact with them)
    ii. In the report, there will be contact information for tribes in most states

G. CT-GC Continuing Education Module (Jennifer Kawatu and Jaya Mathur)
    a. Comments/Feedback
        i. For state labs that use BD Probe Tech, vaginal swabs are not accepted although they are recommended – this information must be clarified in the module
        ii. We may want to add a glossary tab
        iii. We should add links to state STD websites
        iv. We should add in something that this is tailored to Region I and have a link to CDC website for information about other regions and state resources/websites
        v. We should clarify if the CMEs are region-specific or national
        vi. Anyone interested in using the PowerPoint or parts of the presentation, should contact Jaya (jmathur@jsi.com)
        vii. They look very good!

H. Next Steps
    a. Discuss June meeting dates via e-mail