Combined Screening & Treatment and Data Subcommittee Minutes
June 15, 2010

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*Andee Krasner Question to Group:*
Individuals who identify as **only** AI/AN, compared to those who identify as AI/AN **and another race**, have poorer health outcomes, lower educational rates, less pre-natal care and usually are non-English speaking. Given this, do you think it is helpful to separate the Region I epidemiological profile into these two groups?
*Group Response:*
Only 120 self identify as AI/AN, and of that, there is a 90-30 split of identifying as AI/AN with another race. Therefore, it is not worth it to split AI/AN into two groups.
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A. Review State-Specific Progress Toward Meeting Performance Measures (Screening Coverage, Test by Age Group, Time to Treatment FP, STD)
   - ME
     - ME is not sure why its numbers this year are so different from the other states; staff vacancies and leaves has affected this slightly, but overall, but ME is still achieving decent numbers for time-to-treatment
     - ME's screening coverage is good and it is still doing pretty well regarding testing by age group
     - ME's numbers are going down; almost 80% goes out for testing and medication, but the state is expected to try to maintain its numbers
   - RI has met all goals of the second half of the year objectives; RI has added a couple more sites, so it will increase 10% from baseline
   - MA is doing well across the board
   - CT doesn't know why its numbers have gone down; CT added more sites to reach 3% positivity and there are now more positives; CT is completely stopping testing those over 25
   - VT
     - Given the economy, the VT Department of Health has raised cost of testing, which led to loss of a family planning contract
     - VT went from 1100 tests to 600 tests, which is a big dip
     - Given limited funding, it is not realistic that VT will be able to increase testing by 10%
     - VT's 25 and over re-screening data worked out with Planned Parenthood is wildly different from JSI data, which could be related to incomplete data collection
       - There is conflicting data regarding tests by age group
       - This relates to the definition of criteria, which might be off (i.e. it may be related to using symptoms, etc.)
   - NH
     - NH is meeting all of its performance measures
     - NH has a 3% positivity, which is based only on IPP, not on all site data; NH will do an evaluation of that difference
     - NH is meeting all time to treatment guidelines
     - There was also an increase in lab costs
     - There seems to be a NH Chlamydia population shift in age, i.e. the 40+ population is growing and there has been a small surge in 13-14 year olds

B. Review Progress Toward Meeting Regional Objectives (1.1-3.1, 5.1-evaluation) and C. Review & Update Regional Objectives for 2010-2011

- Priority 1 – Expand/target Chlamydia screening to young, sexually active women and men at risk for infection, in public and private settings.
    - Objective 1.1 – By 2011, increase CT screening by 10% of sexually active 15-24 year old women and men. Using 2004 data as the baseline, increase from 28,694 to 32,563 in IPP sites.
        - The subcommittee members say they probably will not be able to increase screening by this amount
        - JSI will have a competitive bid again for IPP in 2012
        - Is 10% too big of an increase given that costs are going up?
        - Subcommittee members propose a lower percentage for the new application
        - Would that make JSI less competitive?
        - Maybe IPP could move to more targeted screening
    - Objective 1.2 - By December 31 of each calendar year, with assistance of JSI, develop, monitor, update and disseminate regional plan and guidelines.
        - All states achieved this objective!
- Priority 2 – Incorporate analysis of regional prevalence monitoring data into regional and local data directed program planning.
    - All states are moving along in this area
    - There is glitchy data regarding how states look at their own data versus JSI's methods; further discussion is needed regarding this issue, e.g. symptomatic vs. criteria screening
        - This could be added to the fall meeting agenda
- Priority 3 – Improve appropriate and timely treatment for persons diagnosed with Chlamydial infection and their partners.
    - All states are doing well with regard to this priority
    - ME has one transportation shut down per month, which affects transit time
    - NH will have a similar problem because it no longer has state courier
    - ME pays for mailing if site is part of IPP
    - MA pays for UPS
- Priority 5 – Increase adoption of "best practices" prevention strategies to reduce Chlamydia transmission.
    - Objective 5.1 – By end of calendar year 2010, there will be an increase of 5% of women rescreened within 3-4 months of completion of treatment.
        - Should we add a re-screening check box to lab slip?
        - MA changed its lab slip at the end of the year, so other states can compare for checkboxes
        - Are states tracking lab slips?
        - Boxes added to one slip should be added to all slips to establish a baseline
        - NH also changed its lab slip; it will include a box indicating whether a test is clearly a re-screen; can educate providers on how to use box
        - There could be a short description on lab slip next to the re-screen box, e.g. "this is a re-screen from within the last 3-4 months"
        - MA has changed a few things to make slips more user-friendly: a "re-screen" checkbox, an "other" box for sex, and an "N/A" box for risks

D. Updating Lab Slips (group decisions)
    - *Re-Screening data* – YES
    - *PTO* – YES (and educate providers on its use)
    - *No Exam Done* (instead of N/A) – YES
    - *Other Gender* – To be decided, because it is not directly helpful to the project but it could be useful to clinicians using the slip with patients. This should be discussed at the next meeting with MA, since it is already included on their slip. Since this group of people identifies as "other," they may also fall into other risk groups.
    - MA will report the addition to their slips at the next meeting, and the subcommittee will use this as a guide for the entire region.

E. Best Practices – Are there report models?
    - RI has good reports
    - NH developed a site visit protocol (from the STD protocol), which is largely comprised of checks regarding whether sites know the screening guidelines; NH will do a report and action plan, which it hopes to integrate into ongoing audits
        - **NH will send this document to JSI for distribution to all the states**

F. Missed Opportunities for Screening
    - Are there other opportunities beyond PTO?
    - NH says that the FP files and primary care files are within the same agency, but there is no communication between them; FP would, however, like to be able to count primary CT testing
    - If clients fit the guidelines, they could be tested for CT if they are walk-in's for HIV testing or EC
    - There is a delicate balance in high volume clinics; it would be difficult to determine who would counsel clients about CT if they are walk-in's
    - If clients just buy EC at the desk, then it is not feasible to get them a CT test

G. Items for Fall Meeting Agenda
    - Report from MA on "other" checkbox under sex and CT rates
    - A longer report on "risk factors" vs. symptoms and recommended testing

***New Chairs – Jennah and Laura***