STD Subgroup Meeting
June 14, 2010

- Bill Smith
  - Bill Smith from the National Coalition of STD Directors (NCSD) attended the subgroup meeting and there was some discussion about why there was a shift in the due date of the CSPS proposal by three weeks (it was not really known but conjectured to be because of CDC internal deadlines)
  - The question was raised about why IPN was more detailed in 2010; the answer was to provide more clarification on the information being asked for, not to put additional emphasis on it
  - Concern was raised that PCSI was designed only for high morbidity states; Bill said he had spoken with CDC about the concerns, and he has three goals for future PCSI FOAs (there will be more because there are additional dollars allocated in the FY11 budget):
    - Fix the process for improved discourse between states and CDC
    - Prioritize the need for models for low morbidity states
    - Create a task force for developing key priorities for low-morbidity areas
  - The point was made that – with additional money for low morbidity states, which are already integrated – states could develop a more sophisticated means of integration and could be models for high morbidity states/areas

A. GC Updates
   a. MA
      i. MA has added GC results to the database
      ii. The case report form includes address, but the lab slip does not include address
      iii. MA has a regional disease intervention specialist (DIS), but it lost the personnel position
   b. CT
      i. CT gets lab slips from eight targeted zip codes (New Haven and Hartford) and do partner notification; lab slips have the address on them
      ii. CT verifies GC treatment
      iii. CT targets African Americans 25 and under and MSM
      iv. There is no CT re-screen follow-up
   c. RI
      i. RI is trying to do treatment tracking and are successful with about 90% of clients
      ii. There are 3 new DIS staff; 60-70% of PS clients have interviews but no contacts are elicited

iii. DIS obtains treatment information and, if fluoroquines are used, they call the clinician and go over the CDC recommendations for treatment

d. ME
    i. There were under 100 GC cases last year and 146 cases of GC this year
    ii. There was an outbreak of GC and an HHAN alert
    iii. ME does GC partner notification
    iv. ME plans to send out CDC Treatment Guidelines when they are released to FQHCs and through collaboration with the Maine Primary Care Association. This is one of the tasks established at last year's GC meeting, as it is challenging to truly target GC in Maine.

e. VT
    i. There were 6 cases of GC last year and 28 this year
    ii. 40% of the cases were imported from out of state or outside the country
    iii. 18% of the cases were in the African-American population, though African Americans make up only 0.8% of VT's population
    iv. VT worked with the Men's Project to get out GC information
    v. VT kicked off an infectious disease bulletin, which included the following information:
        1. VT's population has been impacted by GC
        2. Treatment of GC
        3. A PCSI message about syphilis/HIV/CT/etc.
    vi. VT's DIS position was eliminated
        1. The number of cases is up, and the case contacts have also increased
        2. The average age of those with GC is younger than it used to be

f. NH
    i. There is no STD surveillance position; HIV is covering these responsibilities
    ii. DIS covers GC, CT and HIV
    iii. The GC positive population has changed – there are now more women, and they are younger
    iv. There were 120 GC cases last year
    v. NH is removing GC results from the IPP lab slip
        1. IPP will cover the CT testing only
        2. It will be possible to submit a combo STD test

B. Co-infection
    a. CT
        i. The HIV division is interested in GC co-infection, so matching is done
        ii. PS found 25% positivity of GC on previous negatives, among partners
    b. ME
        i. CT positives get a search for co-infection
        ii. STD does all HIV follow-up
    c. NH
        i. NH does co-infection matching for syphilis and GC, but not for CT or HIV
    d. STD surveillance
        i. STD surveillance is done by the STD program manager in RI, ME and VT
        ii. CT has someone who does TB/STD surveillance
        iii. In NH, surveillance is basically a data entry position
C. Confidentiality
    a. Sharing data across HIV and STD is an issue
    b. Language about confidentiality should be as strong as HIV language, but it was not clear if all states have the facilities for data security measures taken for HIV
    c. ME will share its confidentiality agreement with the group
D. Interest in Regional Training of DIS Staff
    a. Internet training will be conducted by Stephen Adelson with Adam4Adam, and will incorporate the following information:
        i. Cultural competency for working with MSM
        ii. Getting information from popular MSM sites
        iii. Using the Internet effectively for DIS
    b. The basics of partner elicitation will be discussed by Dennis Murphy
    c. There is interest in looking at the second part of 2010 for the training
E. Telephone Interview Training
    a. NH is doing telephone interviewing training for DIS in November
    b. CA DIS will train there
    c. Staff cuts and large geographical areas found in rural areas necessitate using phone interviews
F. Connecticut Social Marketing Project
    a. Connecticut is working with the Department of Education to do social marketing of “Tell me what you see”
    b. Incarcerated individuals made drawings of Hepatitis, HIV and STD, which are used in schools to start discussions about STDs
    c. Is the Department of Education available to preview?
    d. **Connecticut will send out more information** so that the other STD Directors can evaluate; because some DOEs have evidence-based curriculum requirements, it may not be possible