

**REGION II INFERTILITY PREVENTION PROJECT**  
**Regional Committee Meeting**  
**Cicatelli Associates Inc., New York, NY**  
**June 19-20, 2008**

**MINUTES**

**Meeting Purpose:** Provide ongoing support to Region II IPP members in the administration and evaluation of IPP projects in the field in order to support achievement of National IPP priorities.

**Meeting Objectives:**

1. IPP Project Area Partners will develop core objectives and activities to be included in their 2009 CDC IPP Application that are in alignment with 2009 CDC CSPS Competitive Application Guidelines and Priorities.
2. Review current information available about the burden of chlamydia and gonorrhea infection among Urban American Indian populations, examine gaps and develop next steps to increase surveillance efforts.
3. Review and discuss priorities related to the CDC National Data Standardization effort including enhancing collection of gonorrhea surveillance data.
4. Present and finalize proposed FY09 and beyond Region II IPP Meeting frequency and structure.

**Participants**

† Executive Committee Members; ‡ IPP Coordinators; \* Data Managers

ProjArea	Prog	†	‡	*	First	Last	Agency	19-Jun	20-Jun
NJ	STD	†			Patricia	Mason	NJ DHSS	y	y
NJ	STD	†	‡		Carolyn	Tunstall	NJ DHSS	y	y
NJ	FP	†			Debbie	Polacek	NJFPL	y	y
NJ	FP	†			Jo-Ann	Ayres	NJ DHSS	y	y
NJ	FP				Jennifer	Howard	PPGNNJ	y	n
NJ	LAB	†			JoAnn	Hayduk-Kramer	NJ DHSS	y	y
NJ	LAB	†			Paul	Seitz	NJ DHSS	y	y
NJ	STD			*	Patrick	Dwyer	NJ DHSS	y	y
NYC	STD	†			Steve	Rubin	NYC DOHMH	y	y
NYC	STD	†	‡		Meighan	Rogers	NYC DOHMH	y	y
NYC	STD				Julie	Schillinger	NYC DOHMH	y	y
NYC	STD				Shoshanna	Handel	NYC DOHMH	y	y
NYC	STD				Jessica	Borrelli	NYC DOHMH	y	y
NYC	FP	†			Rachel	Baum	Public Health Sol.	y	y
NYC	FP			*	Heather	Clark	Public Health Sol.	y	y
NYC	FP				Jo Ann	Fields	The Door	y	y
NYC	LAB				Quintus	Chess	NYC DOHMH	y	y
NYS	STD				Dennis	Murphy	NYS DOH	y	y
NYS	STD	†	‡		Martha	Newcomb	NYS DOH	y	y

NYS	STD	†		*	Alison	Muse	NYS DOH	y	n
NYS	STD				Gale	Burstein	Erie Co. DOH	y	y
NYS	FP	†	‡	*	Laura	Morris	NYS DOH	y	y
NYS	LAB	†			Scott	Zimmerman	Erie Co. DOH	y	n
PR	STD	†			Greduvel	Duran-Guzman	PR DOH	y	y
PR	STD	†	‡		Bessie	López-Meléndez	PR DOH	y	y
PR	STD			*	Kesia	Mulero Santiago	PR DOH	y	y
PR	FP	†			Carmen	Rivera	Profamilia	y	y
PR	FP				Ana	De Jesús	Profamilia	y	y
PR	FP				Frances	Martínez	Profamilia	y	y
PR	FP				Javier	Velázquez-Grau	UPR TXFPP	y	n
PR	LAB	†			Myriam	García-Negrón	PR DOH	y	y
PR	LAB			*	Adalberto	Díaz-Ortiz	PR DOH	y	y
USVI	STD	†			Gayann	Hall	USVI DOH STD	y	y
USVI	STD	†			Taetia	Phillips-Dorsett	USVI DOH STD	y	y
USVI	STD	†	‡		Rita	Olans	USVI DOH STD	y	y
USVI	STD				Jasper	Lettsome	USVI DOH STD	y	y
USVI	FP	†			Marc	Jerome	USVI DOH FP	y	y
USVI	FP				Mercedes	Reyes	USVI DOH FP	y	y
CDC	STD				Steven	Shapiro	DSTDP	y	y
OPA	FP				Maria	Díaz	OFP Region II	y	y
I.H.S.	STD				Scott	Tulloch	STD Program	y	y
Region II	PTC				Gowri	Nagendra	STD/HIV PTC	y	n
Region III	Infra				Mark	Miller	FPC	y	y
Region II	Infra				Dawn	Middleton	CAI	y	y
Region II	Infra				Kelly	Opdyke	CAI	y	y
Region II	Infra			*	Karl	Labes	CAI	y	y
Region II	Infra				Evelyn	Alvarez	CAI	y	y

**Did not attend:**

ProjArea	Prog	†	‡	*	First	Last	Agency	19-Jun	20-Jun
NYC	STD				Susan	Blank	NYC DOHMH	n	n
NYC	STD			*	Preeti	Pathela	NYC DOHMH	n	n
NYC	FP				Marquita	Rodriguez	PPNYC	n	n
NYC	LAB	†			Lillian	Lee	NYC DOHMH	n	n
NYS	FP	†			Joan	Linton	NYS DOH	n	n
NYS	FP				Eileen	Shields	NYS DOH	n	n
NYS	FP				Lee	Quinlan	Onondaga Co.	n	n
PR	FP	†			Ramon	Sanchez	UPR TXFPP	n	n
PR	FP				Bethzaida	Diaz	UPR TXFPP	n	n
PR	FP			*	Leticia	Román-Torres	UPR TXFPP	n	n

## **DAY 1: Thursday, June 19, 2008**

### **1) New Member Orientation**

- a) Purpose: To provide new Region II Infertility Prevention Project meeting participants with an overview of project history, operations and priorities in order to enhance their understanding of and ability to realize the goals/objectives of the Region II Infertility Prevention Project in their project area.
- b) Participants: Paul Seitz, Chief of Bacteriology, *NJ DHSS Public Health & Environmental Lab*; Carolyn Tunstall, Special Projects Coordinator, *NJ DHSS STD Program*; Jessica Borrelli, City Research Scientist, *NYC DOHMH BSTDC*; Laura Morris, IPP Coordinator – FP, *NYS DOH Bureau of Women’s Health*; Kesia Mulero Santiago, IPP Evaluator, *Puerto Rico DOH STD/HIV Program*; Rita Olans, Nurse Practitioner, *USVI DOH STD/HIV/TB Program*.
  - a. Did not attend: Quintus Chess, Director of STD Clinic Laboratory Services, *NYC DOHMH*; Shoshanna Handel, PHPS Intern, *NYC DOHMH BSTDC*; Frances Martínez, Medical Director, *Profamilia*.
- c) Outcomes: Participants were asked to introduce themselves and their role relative to IPP, and were provided with resource materials (including Regional IPP organizational structure and meeting structure) and an opportunity to ask questions about the project. The agenda included the following:
  - a. Project History (Dawn Middleton)
  - b. Project Priorities [Summary of National/Regional IPP Strategies]
  - c. How the Project Operates
    - i. CDC and OPA – Memorandum of Agreement
    - ii. Region II IPP Infrastructure [Cicatelli Associates Inc.]
    - iii. Regional Committee [Regional Plan, WorkGroups/Task Forces]
    - iv. Project Areas [Project Area IPP Coordinator]
    - v. Chlamydia and Gonorrhea Prevalence Monitoring
  - d. Review June 19-20 Meeting Agenda
    - i. Focus on preparation of IPP section of FY2009 Comprehensive STD Prevention Services (CSPS) grant

### **2) Introductions and Welcome [General Session]**

*Steve Rubin, Co-Chair and Debbie Polacek, Co-Chair*

- a) Steve and Debbie welcomed the group back to New York City and Cicatelli Associates for another meeting.
- b) Everyone in attendance introduced him/herself, including new members.
- c) Dawn briefly reviewed the objectives and agenda for the two-day meeting.

### **3) Region II IPP Timeline 1993- 2008**

*Dawn Middleton, Region II IPP Director*

Dawn reviewed the history and milestones of the IPP project from its inception as a pilot project in 1988 through 2008, laying the foundation for “What’s Next”.

The timeline was divided into five areas:

- a) Pilot Project (1988-1992): Region X, Seattle, WA
- b) Birth of the National IPP (1993-1998): Infrastructure Building, Training, Expansion

- c) HEDIS, NAAT, CT Reportable in 50 States (1999-2003): Sustain/Maintain, Research, Innovations
- d) Monitoring/Evaluation, Expedited Partner Treatment, National Chlamydia Coalition (2004-2008): Monitoring/Evaluation, Targeting Resources, Health Disparities, Innovation
- e) What's Next? (2009-2011): Looking forward to competitive CSPS

**4) Review of 2009 CDC IPP Portion of Competitive CSPS Application**  
*Steven Shapiro, CDC National Infertility Prevention Project Coordinator*  
***PowerPoint presentation available online.***

- a) Budget cross-cutting rescission of 1.747%
- b) Infrastructure Update:
  - a. Inter-agency agreement with OPA, 3-year competitive cycle
  - b. Continued support for Providing Confidential Adolescent Health Care (PCAHC) initiative
  - c. Infrastructure Program Evaluation – Measures of Effectiveness
    - i. Estimated screening coverage in FP – 45% among 15-24 yo Region II
    - ii. Test utilization in FP – 60% of tests used among 15-24 yo Region II
- c) Future of IPP: Congressional Intent
  - a. Public Health Law Section 318A: Provide clinical services to at-risk women (and their sex partners) for the purpose of preventing STD-related infertility.
- d) Infertility Prevention Workgroup
  - a. National Chlamydia Coalition
  - b. National Chlamydia Screening Coordinator (Raul Romguera, DMD, MPH)
- e) **CSPS 2009: 5-year cooperative agreement (due August 22, 2008)**
  - a. **Continued emphasis on completing required IPP activities:**
    - i. Ensure CT and GC screening and treatment
    - ii. Do not screen if you cannot treat
    - iii. Support laboratory testing
    - iv. Ensure collection and reporting of all CDC core data elements
    - v. Program Management
    - vi. Provider Training.
  - b. **Data Driven Programs**
    - i. 3% Positivity Threshold among women < 26 years of age
      - 1. Applies to ALL facilities reporting data into the prevalence monitoring system
      - 2. If facility has <3% positivity among females < 26 years of age, plan to increase positivity in facilities or reallocate resources
    - ii. Up to 10% of total awarded IPP funds must be used to target gonorrhea screening among women <26 years or age
    - iii. Male screening up to 15% of total IPP award
  - c. **Integration and Health Disparities**
    - i. Focus on American Indians and Alaskan Natives
  - d. **Title X Concurrence Letter**

- i. Spending plans for the 50% should be developed in partnership with all project area level Title X grantees as documented by the required concurrence letter.
  - ii. Does not require the 50% be spent on Title X grantee clients exclusively.
- e. **CSPS prohibits IPP financial support of DIS**
  - i. Does not preclude CSPS- or SE-funded DIS from performing CT- and GC-related disease intervention activities
- f. **Changes to Project Area Performance Measures**
  - i. Some shift to broad outcomes and sub-measures
  - ii. Timeliness of Treatment remain for Family Planning and STD clinics
- g. **Questions from Participants:**
  - i. When will CDC begin monitoring Pelvic Inflammatory Disease (PID)?
    - 1. Chlamydia is only one cause of PID
    - 2. Hospital in-patient treatment data for PID is the best data available currently
    - 3. CDC will convene a Reproductive Health Consultation, including a discussion of infertility, later this year
  - ii. Will national data standardization efforts extend to laboratory test type or National Laboratory Reporting System? (e.g. FLIP Project, 5-7 states working on two-way data transfer).
    - 1. This question would be best addressed to John Papp. **Include John in December 2008 regional meeting if appropriate.**

5) **Region II IPP Timeline 2009 and Beyond**

*Facilitated by Dawn Middleton, Region II IPP Director*

What's Next? (2009-2011): Group discussion/brainstorm

- Focus age-based screening
- Use morbidity to target screening
- Improve opportunities for screening males
- Male screening in corrections
- Retesting females per CDC guidelines
- Ct partner services strategies including counseling messages/provider education'
- Legal statutory charges to promote partner management and prevalence data reporting
- Educate IPP providers re: CT screening
- Sentinel system for PID surveillance and other long-term sequelae
- PTO/EC Walk Ins
- Capitalize on urine screen in non-traditional sites (example: drug rehab)
- Promote urine/vaginal swab specimen collection. Including non-clinic settings
- Explore lab capacity to process non-genital specimens (off-label use of NAAT)
- CT/GC screening in high morbidity zip code, collaboration between, STD, FP, School, Substance abuse and other agencies
- Analysis of co-infection
- Use of data for program planning
- Strategies to address disparities

6) **IPP Program Model 2009 and Beyond**

*Facilitated by Dawn Middleton, Region II IPP Director*

*[A copy of the Logic Model is available online.](#)*

- a) Participants were divided into groups and asked to consider IPP-related:
  - a. Activities/interventions/strategies that are designed to bring about desired outcomes,
  - b. Short-term outcomes (for which our program is directly accountable), and
  - c. Intermediate outcomes (for which our program is accountable though there tend to be more influences)
- b) The results of the group exercise were compiled by the Infrastructure and reviewed by the Executive Committee.
- c) Six primary strategies/interventions were identified and incorporated into the regional model. **The Executive Committee reviewed these strategies on Day 2 and agreed that each project area would include at least one of these interventions into their 2009 CSPS application:**
  - a. Provide CT Testing During pregnancy test only (PTO), emergency contraception (EC), and HIV testing visits for females age <25 in Title X Clinics and Females Age <29 in STD Clinics who do not see a physician or do not receive a pelvic exam
  - b. Geographic (zip code) targeting of GC/CT testing and outreach in high morbidity areas with existing (FP, STD, Lab) and new partners (“All Out Assault”)
  - c. Conduct IPP focused public health detailing among FP providers (includes: implementation of CDC guidelines, individual provider performance review, use of data)
  - d. Identify and implement effective strategies to increase treatment rates within 14 days of CT/GC specimen collection for patients who test positive in FP/STD clinic settings
  - e. Identify/implement effective CT/GC partner management strategies
  - f. Among sites selected for public health detailing provide training on PID diagnosis and methods for tracking diagnosis data

7) **Urban American Indians [LUNCH PRESENTATION]**

*Guest Speaker: Phoebe Mills, MSW, American Indian Community House, NYC*

*[PowerPoint presentation available online.](#)*

- a) American Indian House
  - a. American Indian House in NYC primarily provides social service support and referrals for health care to AI/AN population in NYC
  - b. At the current time they offer no clinical services but hope to do so in the future
- b) AI/AN National Demographics
  - a. US Census data indicate that U.S. Native Population is 4.1M [or 1.5% of total U.S. population]
    - i. 2.5M identified as AI/AN Alone
    - ii. 4.3M AI/AN in combination with another race/ethnicity
  - b. 2.8M live in or near cities and the number is growing

- c. Nearly 7 out every 10 AI/AN are in urban areas
- d. NYC is home to the largest urban Indian population in the US
- e. 50% of all non-elderly AI/AN are poor or near-poor with family incomes below 200% federal poverty level
- c) AI/AN Health Disparities
  - a. 2008 UIHI BRFSS indicate that twice as many urban AI/AN as compared to non-AI/AN rated their own health as “poor”
  - b. Disparities exist for AI/AN when examining rates of obesity, diabetes, stroke, some cancers, suicide, depression and substance abuse
- d) Barriers to AI/AN Accessing Health Care
  - a. Current services are under funded [1% of total available funding is available for use with urban AI/AN] and most care is available on reservation only
  - b. Inadequate number of culturally competent providers
  - c. There is a significant lack of DATA available that hinders our ability to understand and address health inequities among AI/ANs especially for urban AI/AN
    - i. **Often times “no data” is interpreted as “no problem”**
    - ii. How “mixed race” AI/AN are being counted varies from report to report and jurisdiction by jurisdiction

*[NOTE: Special Topic – Urban American Indians, Continued on Day 2]*

## 8) **CDC IPP Application Development Workshop**

- a) Part I. Defining Base Program Population and Estimated Costs to Test and Treat - Title X/ STD Clinics  
*Program Planning and Management Worksheet is available online.*
  - a. The purpose of this portion of the Workshop was to examine and estimate the current base costs to test and treat for chlamydia and gonorrhea among the target population of females <26 years of age in family planning and females <29 years of age in STD. The Workshop examined variables related to lab and treatment costs and most current chlamydia and gonorrhea positivity rates. Estimates were developed modeling 100% screening coverage in the target population and costs to test and treat based on actual screening coverage.
  - b. To ensure that participants were prepared to participate in the Workshop, in advance of the meeting, project area IPP Coordinators were asked to complete the Program Planning and Management Worksheet detailing IPP program budget allocation, cost for laboratory test technology, the number of unique female clients served by age group in STD and FP settings, and case rates as reported by the project areas.
  - c. **Project areas were provided with data summary tables in binders** (“Chlamydia and Gonorrhea Data Monitoring & Evaluation Summary Report 2004-2007”) in order to assist with the completion of this exercise. All data tables were also sent to projects via email prior to the meeting. Binders included worksheets as completed by the project areas, a series of 16 detailed prevalence monitoring summary tables (analyzed for females by age group,

facility, county, and race/ethnicity), as well as estimates of screening coverage based on FPAR data and adherence to screening criteria and rescreening rates where available.

b) Innovative Strategies to Increase Identification of CT/GC

a. **Express Visits (NYC, Jessica Borrelli, MPH)**

*PowerPoint presentation available online.*

- i. Background: The NYC Department of Health and Mental Hygiene Bureau of STD Control (BSTDC) operates 10 STD clinics in city-wide. Services include diagnosis and treatment for gonorrhea (GC), chlamydia (Ct), syphilis and herpes, HIV & Hepatitis C testing, Hepatitis A & B vaccinations, Pap smears & emergency contraception. Physicians provide all clinical care.
- ii. “Express Visit” option defined:
  1. Defined as STD screening visit without physician exam
  2. First conceived in 2006, following increase in overall patient volume related to introduction of rapid HIV testing
  3. Criteria for eligibility (determined at triage by trained staff):
    - a. Asymptomatic
    - b. No known contact to an STD case
    - c. Do not need to or decline to see an MD
  4. STD screening tests offered during an Express Visit:
    - a. GC and Ct (urine Nucleic Acid Amplified Test)
    - b. Syphilis RPR (blood draw)
    - c. HIV testing (rapid oral swab)
- iii. Analysis: Evaluated the impact of routine express visits on the diagnosis and treatment of CT and GC (Sep-Dec 2005 versus Sep-Dec 2006)
  1. Number of patient visits increased 23% overall
    - a. Express Visits increased by 311% (from 1,476 to 6,064)
    - b. Express Visits Accounted for 25% of all visits in 2006
  2. Proportion symptomatic for MD visits increased by 16%
  3. Number CT/GC tests performed overall increased 23% (MD visits and Express Visits combined)
  4. 9% of Express Visits tested CT/GC positive in 2006, compared with 15% of MD visits
  5. No presumptive treatment for Express Visits means time to treatment longer for Express Visits (82% treated within 30 days compared with 96% of cases identified during MD visits )
    - a. Steps must be taken to ensure appropriate follow-up
- iv. **Conclusions: Express Visits resulted in more cases identified and treated and made better use of limited physician resources**
- v. Discussion:

1. Facilities that see a large number of pregnant women or other high-risk clients may need to adapt Express Visit eligibility criteria according to the needs of their population.
2. Evaluation should consider opt-out rate for blood draw (Syphilis and HIV) and examine possible missed cases to ensure adequate triage criteria

**b. STD Screening at EC Visits (NYC, Shoshanna Handel, MPH)**

*PowerPoint presentation available online.*

- i. Background: Free Emergency Contraception (EC) offered to women in 10 NYC DOHMH STD clinics since 2003 (no advance provision, walk-ins)
- ii. Analysis: Based on review of Electronic Medical Records (EMR) “reason for visit” data (Oct 2005 to April 2007):
  1. 2,460 EC-request visits per year (5% of all female visits)
  2. 75% of EC requests are from females <26 years
  3. 60% EC-only visit = no other services requested
  4. 4% of EC-only visits were tested for CT/GC (8% positive)
  5. Females <26 years requesting EC are less likely to be tested for CT/GC but more likely to test positive
- iii. Conclusion: **EC-request visits represented a missed opportunity for CT/GC testing of young women at risk**
- iv. Follow-up (Nov 2007 to May 2008): New protocol to offer STD test at all EC visits (assume 2,500 EC-request visits per year, 11% positivity)
  1. New protocol detects 88 more CT/GC infections per year.
  2. If 90% of EC-requesters were tested, would detect 168 more infections per year than under original protocol.

Scenario	% of EC-Requesters Tested	# Tests Done / Year	# Infections Detected / Year
Original Protocol	29%	725	80
New Protocol	61%	1,525	168
Ideal World	90%	2,250	248

- v. Discussion
  1. New York City is considering implementing QuickStart for contraception; would integrate with existing EC and STD testing services.
  2. Opt-out HIV testing is also offered to EC-requesters (in addition to CT/GC testing). 61% uptake compared with 25% baseline.
  3. EC visit type (EC-only or EC-plus) is determined at triage (not clinician driven).

**c. Program Collaboration & Service Integration (CDC, Steven Shapiro)**

*PowerPoint presentation available online.*

- i. **Priority for 2009 CSPS.** Program Collaboration and Service Integration (PCSI) is an initiative of the CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP).
- ii. **Definition:** PCSI is defined as "A mechanism of organizing and blending inter-related health issues, separate activities, and services in order to maximize public health impact through new and established linkages to facilitate the delivery of services."
- iii. Integrating HIV, Viral Hepatitis, STD, and TB Prevention Programs
  - 1. Integrated services may include HIV, STD and hepatitis B/C counseling and testing, partner services and referral to additional prevention or care and, hepatitis A/B immunization.
  - 2. Integration should be focused at the field or client level where the interface between the system and the consumer takes place.
  - 3. We use the term integration in the sense that it results in integrated services for clients, regardless of the agency structure.
- iv. **Discussion**
  - 1. **IPP projects should consider** opportunities for integration of services beyond STD, HIV, TB and Hepatitis, for example:
    - a. HIV and STD testing in FP clinics
    - b. EC and QuickStart offered in STD clinics
    - c. Substance abuse screening in STD clinics, etc.
  - 2. Limited resources to support PCSI; however, cost savings and increased efficiency may be possible through integration.

c) Part II. Chlamydia Screening Strategies

***Program Planning and Management Worksheet is available online.***

- a. This was a continuation of the Program Planning and Management exercise. The focus of this section was on utilizing available program data to develop project area objectives and activities related to chlamydia screening, in consideration of 2009 CSPS priorities.
- b. *NOTE: This session was conducted on Day 2 due to time constraints.*

d) Part III. Target Gonorrhea Screening to Reduce Health Disparities

***Program Planning and Management Worksheet is available online.***

- a. Continuation of Part II, above, but focused on targeted screening for gonorrhea in high-morbidity areas in order to address health disparities.
- b. *NOTE: This session was conducted on Day 2 due to time constraints.*

9) **Data Standardization, Monitoring and Evaluation – 2009 and Beyond**

***Special Session - Detailed notes are available online.***

- a) Purpose: To discuss IPP National Data Standardization, and Monitoring and Evaluation efforts in conjunction with Region II IPP general meeting.
- b) Participants: Project Area Data Managers and Key Program Managers

- c) Outcomes: A summary of next steps from this meeting is provided below, and should inform development of 2009 CSPS activities for IPP surveillance, prevalence monitoring and data management:
  - a. **Project areas should** continue to submit data to Infrastructure following regional codebook standards, which have been updated to reflect changes to required (core) variables as specified in CDC national codebook.
  - b. As per updated regional codebook, **project areas should** establish plans to revise data collection systems (e.g. lab requisition forms) to:
    - i. Reflect new values for chlamydia test type (“CTTSTTYP”).
    - ii. Capture gonorrhea test type as a separate variable (“GCTSTTYP”).
    - iii. Capture additional specimen type categories for “oropharynx” and “vagina”.
  - c. **Project areas should** develop a plan for improving the completeness and accuracy of prevalence monitoring data submitted based on information gathered from the Quarterly QA Reports, in addition to issues identified during data cleaning prior to submission to the Infrastructure.
  - d. **Project areas should** submit quarterly data to the Infrastructure within 60 days of the close of each quarter, as per regional data submission protocol.
  - e. **Data managers should** be prepared to facilitate future assessment of chlamydia rescreening practices, as per the established regional methodology.
  - f. **Project areas should** ensure that surveillance systems are in place to collect information required to respond to:
    - i. CSPS performance measures related to chlamydia screening in juvenile detention and timely treatment of CT/GC among females.
    - ii. Regional performance measures related to chlamydia screening coverage and test utilization by age group for females in family planning.

**DAY 2: Friday, June 20, 2008**

**10) IPP Executive Committee Meeting**

*Special Session - Detailed notes were distributed to meeting participants.*

- a) Purpose
  - a. Review the Region II IPP Logic Model developed on Day 1 of the meeting and to come to consensus on adoption of proposed model;
  - b. Review priorities for objectives and activities for inclusion in the IPP portion of the 2009 CSPS application;
  - c. Review and confirm regional meeting structure moving forward.
- b) Participants: Executive Committee members (designated STD, Title X and Lab representatives) and IPP Coordinators for each project area.
- c) Outcomes
  - a. **Each project area will include at least 1 strategy/intervention from the Region II Logic Model and incorporate into their 2009 CSPS application as an objective or activity.**
  - b. Members were reminded that they should include objectives/activities related to the items listed below. It was noted that data to support the development of baseline measures for inclusion within objectives could be found in the

“Chlamydia and Gonorrhea Data Monitoring & Evaluation Summary Report 2004-2007” binder distributed on Day 1 of the meeting:

- i. Participation in the regional process [including regional meetings, task forces and work groups].
- ii. Target Gonorrhea Screening
- iii. Increasing Screening Coverage
  1. Application of urine/vaginal swab NAAT when a pelvic exam is not being conducted
  2. Increasing re-testing rates per CDC Guidelines
- iv. Addressing CT 3% positivity threshold for females <26 years of age
- v. Addressing Time to Treatment per CDC Performance Measures
- c. The Executive Committee re-affirmed the following meeting structure:
  - i. 1 Full Day Executive Committee Meeting [Fall 2008]
  - ii. 1.5 Day Regional Committee Meeting [Spring/Summer 2009]
  - iii. Individual Project Area Site Visits throughout the year

**11) Special Topic – Urban American Indians** [*Continued from Day 1*]

a) Urban American Indians – IHS National STD Program Goals/Objectives

*Scott Tulloch, Program Director, IHS National STD Program*

***PowerPoint presentation available online.***

- a. Scott provided an overview of STD-specific concerns for the AI/AN population. The following are highlights from the presentation.
- b. STD Rates
  - i. AI/AN 2nd in GC/CT Rates and 3rd in P/S Syphilis Rates
  - ii. Chlamydia Screening program in Indian Country:
    1. 52 sites
      - a. 38 HIS facilities
      - b. 12 Tribal
      - c. 2 Urban
    2. 63, 635 CT specimens [89% female]
    3. Overall Positivity [6.4% Female, 12.5% Male]
- c. Lack of Data: There is a lack of nationally and locally available data to further describe disease burden and health care seeking behavior among AI/AN
  - i. Region II – no CT/GC prevalence monitoring data available for AI/AN in annual prevalence monitoring report
  - ii. Often race/ethnicity data in morbidity reports is missing or misclassified
  - iii. IHS providers are generally not located off reservation – for those AI/AN living off reservation – where are they getting care?
  - iv. IHS is a Primary Care Model focusing on TB, obesity, substance abuse and diabetes – No centralized health data exists about the delivery of these services or who accesses these services
- d. Next Steps for Project Areas and Region
  - i. Quantify Current Population

- ii. Assess Access to Services and Health Seeking Behavior
- iii. Describe current efforts to reach out to AI/AN population
- iv. Describe Burden of STD/HIV/TB with existing data consider challenges in the collection of accurate data and interpretation of existing data [especially as it related to calculating base population and STD rates and inclusion of “mixed race” AI/AN]

b) Project Area Presentations – Urban American Indian Surveillance Data

a. **New York City, Julie Schillinger, MD, NYC DOHMH**

*PowerPoint presentation available online.*

- i. Julie described current challenges and presented preliminary surveillance data on burden of STD/HIV/TB infection among AI/AN population in NYC.
- ii. Quantify current AI/AN population in NYC
  - 1. When Julie accessed the NYC DOHMH Policy and Planning Office Website it noted that 17,321 AI/AN reside in NYC [.2% of a population of more than 8M]
  - 2. US Census Website noted that 41,289 are AI/AN alone and 87,241 AI/AN in combination with another race/ethnicity resided in NYC
  - 3. Significant disparity between US Census Data and Local Data in estimates of base population of AI/A
- iii. Currently available data indicates very small numbers of cases of STD/HIV/TB are reported to the Health Dept who identify as AI/AN.
  - 1. 2006: 9 cases of HIV [male and female]
  - 2. 2006: 0 cases of TB
  - 3. 2006: 72 cases of CT [male and female]
  - 4. 2006: 20 cases of GC [male and female]
  - 5. 2006: 2 case of P/S Syphilis [male and female]
  - 6. 2007: Reported visits to NYC STD clinics: 1,059 [AI/AN in combination with other race/ethnicity]
- iv. NYC DOHMH Conclusions: **Measures of AI/AN population are greatly affected by inclusion of individuals who indicate multiple race or Hispanic ethnicity,** and can dramatically affect disease rates

b. **New York State, Martha Newcomb (on behalf of Alison Muse, MPH), NYS DOH STD**

*PowerPoint presentation available online.*

- i. Martha reported that NYS provides a considerable amount of funding [\$1M] to tribal entities but they have very little information from those programs about how they implement their STD/HIV/TB programs or morbidity data
- ii. 7 recognized tribes in the area
- iii. 9 IHS Health Centers in the state [8 of the 9 provide health services]
  - 1. 4 are federally funded

- 2. 5 are state funded
- iv. In any given year less than 100 cases of STDs [including CT/GC and Syphilis] reported are being identified as AI/AN

**c. New Jersey, Patricia Mason, NJ DHSS**

Patricia noted that reported STD/HIV/TB morbidity for AI/AN populations in the state was virtually non-existent.

c) Urban American Indian Health – Region II IPP Next Steps

- a. **Region II should standardize approach** used to collect numerator and denominator data when considering AI/AN populations, disease burden and calculations of case rates
- b. **Region II should consider best practices** in collection of Race/Ethnicity data and examine current data submitted to the prevalence monitoring system to identify gaps in submission of race/ethnicity data

**12) Report from the CDC National Chlamydia Coalition Meeting**

*Gale Burstein, MD, Erie County Department of Health*

- a) Gale attended this meeting on June 5, 2008 in Washington, DC as a representative of the Society for Adolescent Medicine (SAM)
- b) Goal of NCC is to identify undiagnosed cases of chlamydia
- c) Approach: Bring together stakeholders and interest groups from across private sector
- d) NCC Coordinated by Partnership for Prevention (P4P); behind the scenes support
- e) National Chlamydia Screening Coordinator hired March 31, 2008: Raul Romguera, DMD, MPH

**13) Region II IPP Meeting Structure 2009 and Beyond**

- a) As discussed in the Executive Committee meeting, the following meeting structure was adopted moving forward:
  - a. 1 Full Day Executive Committee Meeting [Fall 2008]
  - b. 1.5 Day Regional Committee Meeting [Spring/Summer 2009]
  - c. Individual Project Area Site Visits throughout the year
- b) The first meeting of the Executive Membership to be held in NYC on Friday, December 5, 2008 for 1 Full Day
  - a. **[Addendum: The meeting date was subsequently changed to Friday, December 12, 2008 over 1 Full Day].**
  - b. As decided earlier, IPP Coordinators should plan on attending this meeting.

**14) LUNCH [Private Sector Task Force Meeting]**

*This session was cancelled due to lack of attendance of key members.*

**15) Project Area Meetings – Continue Development of IPP Applications**

*Continuation of project area collaboration started on Day 1.*

**16) USVI IPP Partners Meeting [USVI STD and FP IPP Partners Only]**

*Special Session - Detailed notes distributed to meeting participants*