

**Data Subcommittee Agenda Items  
Region IV IPP Advisory Board Meeting  
May 7, 2010**

Participants:

- Mary Scisney, AL DPH
- Adrian Cooksey, FL DOH
- Reginald Robinson, GA DCH
- Linda Allen-Johnson, GA DCH
- Kenya Taylor, GA DCH
- Sheri White, KY DPH
- Pete Moore, NC DHHS
- Mickey McCowen, TN DOH
- Scott Tulloch, IHS
- Erin McClain, UNC Sheps Center
- Kelly Opdyke, Cicatelli Associates Inc. (Facilitator)

Notes:

1. Quality Assurance Issues - missing data and possible solutions
  - a. Reviewed purpose and format of quarterly QA reports.
    - i. Infrastructure distributes to project are IPP Coordinators and Data Managers for each state quarterly, and identifies trends or observations that may require further attention.
    - ii. A special emphasis was given the Facility Reference Files for 2009 year end data submission.
  - b. By November 2010, Infrastructure will provide a summary of which states are currently reporting "enhanced" variables (i.e. those not required by CDC) to determine whether and how these data may be used to inform regional efforts.
2. Feedback from 2009 data set
  - a. Overall, great work!
  - b. All states have been reporting using the CDC national codebook format since 2008.
  - c. All but one project area was able to submit 2009 end of year data by the April 1, 2010 deadline. All projects areas submitted 2009ey data by April 15, 2010.
  - d. Tennessee corrected an error in coding for specimen source in 2009q3, and can now better monitor urine-based screening.
  - e. Infrastructure contacted individual states about other issues of interest or concern, including variations in test volume over time by clinic site.
  - f. Facility Reference Files
    - i. Preferably only changes need should be submitted to Infrastructure; if submitting a new file quarterly, data memo should note what has changed.
  - g. Quarterly Data Memos
    - i. Not every state is submitting data memos consistently. These are meant to provide programmatic context to data trends (i.e. changes in testing protocols, clinic closures, new screening sites), as well as to confirm the record count for each file submitted.
    - ii. A template was provided at meeting, and is usually sent with quarterly data reminders.
    - iii. Infrastructure will continue to request additional information missing data memo.

3. Opportunities for additional screening in non-traditional venues and capturing that data
  - a. Alabama provided access to PHL for sites when possible (courier service was the greatest challenge).
  - b. AL also created an online data capture tool for juvenile detention sites that send samples to CDD instead of state lab.
  
4. Gonorrhea screening - update from states
  - a. States were asked to report out on GC indicators and progress in action plans during general session, but were not asked to formally prepare materials ahead of time for this meeting. These measures will be monitored over time.
  - b. A template for reporting out data will be developed for the Fall 2010 meeting to allow continued monitoring.
  - c. The group felt the indicators were still relevant, but acknowledged that each state had varying capacity to report out by zip code or census tract.
    - i. Florida and Tennessee use PRISM, which requires verification of index patient's address at the time it is entered into the system. Census tract mapping can then occur spontaneously in MapMarker.
    - ii. Alabama enters client's address, but would most likely have to go back and manually verify and code the census tract in order to conduct Geographic Analysis. Mary was going to investigate this further.
  
5. Capturing data from Native American testing
  - a. Race/ethnicity is supposed to be self-reported, but clients may not report AI/AN identity for fear of stigma, or staff may assume a person's race and ethnicity based on how they look or speak.
    - i. "You Decide" campaign has been successful in increasing rates of reporting race and ethnicity in Michigan and other project areas.
    - ii. Programs may identify additional AI/AN clients if they allow clients to select more than one race and assess screening for any client that selects AI/AN (alone or in combination with another race)
  - b. North Carolina had a successful partnership with the Lumbee Indians; that's where most of the AI/AN data for the region currently come from.
  - c. Indian Health Service sites are not currently reporting to IPP (largely because they do not use the state labs).
  - d. See also notes from AI/AN lunch session for details of state involvement with AI/AN.
  
6. Data component of IPP Guidelines
  - a. Infrastructure proposed the following edits overall:
    - i. Adding an Introduction that described the purpose of IPP prevalence monitoring and data submission.
    - ii. Removing Data Codebook from within the "guidelines" document, and instead linking to the current codebook which is already posted to the Region IV IPP website.
    - iii. Updating list of required variables to reflect Facility Reference File and current CDC "core" variables for Prevalence Monitoring Database
  - b. Group discussed proposed changes to data 2010 guidelines for Data Collection, but wished to review and provide additional comments.