

**Title:** Region IV IPP Spring Advisory Board Meeting  
**Date:** Thursday, October 8, 2009 – Friday, October 9, 2009  
**Location:** Embassy Suites Historic Charleston, 337 Meeting Street, Charleston, SC 29403

**Participants:**

<u>State</u>	<u>Participant Name</u>	<u>Affiliation</u>	<u>STD</u>	<u>FP</u>	<u>Lab</u>	<u>Other</u>
AL	FLEETWOOD HINES	ADPH			✓	
AL	ELIZABETH NICHOLS	ADPH		✓		
AL	MARY SCISNEY	ADPH	✓			
FL-CHC	MARIE-JOSE FRANCOIS	FL - CHC		✓		
FL	ADRIAN COOKSEY	FL DOH	✓			
FL	MARGARET RANKIN	FL DOH		✓		
FL	DEAN WILLIS	FL DOH			✓	
GA	LYNDOLYN CAMPBELL	GA DHR		✓		
GA	KRISTEN DIXON-BARNES	GA DHR	✓			
GA	MAHIN PARK	GA DHR			✓	
GA	REGINALD ROBINSON	GA DHR	✓			
KY	WILLIAM BAKER	KY DPH			✓	
KY	DEBRA ISRAEL	KY DPH		✓		
KY	SHERI WHITE	KY DPH	✓			
MS	KENDRA JOHNSON	MSDH	✓			
MS	DAVID PEYTON	MSDH	✓			
MS	DIETRICH TAYLOR	MSDH		✓		
MS	CHANEY WALTERS	MSDH			✓	
NC	MARY-NOEL DODD	NC DHHS			✓	
NC	RON HIGGINBOTHAM	NC DHHS	✓			
NC	CHERYL KOVAR	NC DHHS		✓		
SC	SARAH ANNE FELLOWS	SC DHEC		✓		
SC	BRENDA HASTIE	SC DHEC			✓	
SC	CONSTANCE PERKINS	SC DHEC	✓			
TN	JIM GIBSON	TN DOH			✓	
TN	MARGARET MAJOR	TN DOH		✓		
TN	JEANECE SEALS	TN DOH	✓			
GA	STEVE SHAPIRO	CDC				✓
GA	CATHERINE SATTERWHITE	CDC				✓
GA	EDECIA RICHARDS	OPA				✓
SD	RICK STEECE	NCLC				✓
CA	PETE KELLEY	GEN-PROBE				✓
NC	ERIN MCCLAIN	UNC-SHEPS				✓
NC	RENÉE FERRARI	UNC-SHEPS				✓
NY	DAWN MIDDLETON	CAI-NYC				✓
NC	KELLY OPDYKE	CAI-NYC				✓
GA	CASSANDRA MALONE	CAI-ATLANTA				✓
GA	GINA MARTIN	CAI-ATLANTA				✓
GA	DANA PEEBLES	CAI-ATLANTA				✓

## MEETING MINUTES

### Meeting Objectives

1. Finalize and adopt July 2009\_June 2011 Region IV IPP Regional Plan [Logic Model] that is consistent with CDC National IPP Priorities as articulated in the 2009 CSPA Competitive Application and informed by science and data.
  - a. Revised and adopted by consensus with the following edits
    - i. Priorities B and C, updated language (per CDC) from “eliminate health disparities” to “ensure health equity”
    - ii. Activity 6, revised to reflect more broadly support for adoption of new laboratory guidelines (not just discontinuing repeat testing)
2. Review state progress in implementing strategies to reduce GC health disparities and consider future activities including development of regional monitoring and evaluation plan.
  - a. All states presented updates on GC plans, including target area, strategies, and indicators
  - b. Facilitated group discussion to identify specific indicators
  - c. Data subcommittee (with Erin and Titi) identified two they recommend for further consideration
    - i. # “core” IPP facilities reporting testing and positivity in target areas for at least 3 years
    - ii. # GC cases reported in target area annually by age, sex, race/ethnicity, county, zipcode, provider [statewide/in target area]
  - d. Data subcommittee wants to convene a conference call this month (October) to finish this discussion and finalize recommendation.
3. Establish date, location, objectives and draft agenda items for the Spring 2010 Region IV IPP Advisory Committee Meeting.
  - a. Group selected Fort Lauderdale, May 6-7, 2010
  - b. (No interest whatsoever in going to Atlanta)

**October 8, 2009** [8:00am – 4:15pm]

**8:00 – 8:30am Continental Breakfast [available all morning]**

**8:30 – 8:45am Welcome and Introductions**

*Constance Perkins, Chair Region IV IPP Advisory Board*

**8:45 – 8:50am Meeting Objectives and Outcomes**

*Constance Perkins, Chair Region IV IPP Advisory Board*

**8:50 – 9:15am Review and Adoption of Region IV IPP Logic Model**

*Constance Perkins, Chair Region IV IPP Advisory Board*

1. Logic Model was reviewed and adopted by the full Advisory Board

**9:15 – 10:00am CDC Update**

*Steven Shapiro, CDC National IPP Coordinator*

1. New directions under Thomas Frieden
  - a. Office of Health Disparities is now Office of Health Equities
  - b. Requested from Epi branch an estimate of “what 100% screening coverage would look like”
2. STD Awareness campaign
  - a. Prelim data for 78/98 participating PP affiliates. Biggest success story was PP Rocky Mountains: 1416 CT tests in 2 days (vs. 78 in one typical day). Charged patients \$5 for a dual test.
  - b. 10 affiliates in Region IV participated.
3. Revised STD guidelines pending
  - a. Language regarding rescreening will be stronger than in the past
4. Lab update
  - a. Quest and LabCorps are now cleared to run rectal and pharyngeal specimens
5. Expedited Partner Treatment (EPT)
  - a. Not a billable service in most states
  - b. 340B drugs cannot be used for EPT (or contraceptives)
6. IPP Coordinators (Baltimore) will discuss enhanced variables and whether regions want to keep collecting variables that are not used.

**10:00 – 10:15am            BREAK**

10:15 – 11:30am            **Gonorrhea Health Disparity State Reports – Progress on Action Plan**  
*State Representatives [AL, GA, TN, KY, FL, SC, NC, MS]*

1. Alabama (Mary)
  - a. Target:
    - i. Five counties; 74% of morbidity is in seven counties
    - ii. Many rural counties have high rates, low volume
    - iii. 34% of cases are reported from STD clinics
    - iv. African Americans represent 68% of reported cases
  - b. Plan:
    - i. More thorough use of data
    - ii. Expanded DIS interviews
    - iii. Community engagement – Public Health Detailing
      1. Abstinence only programs pose a challenge
      2. Reaching out to CHCs, Jails, Job Corps, HBCUs, Planned Parenthood sites
2. Georgia (Kristen)
  - a. Target:
    - i. Clayton and Albany (Dougherty County) Districts
    - ii. Account for <10% of morbidity statewide
    - iii. Selected because DIS resources are more readily available
  - b. Plan:
    - i. Interview all GC cases, partner services
    - ii. Timely treatment
3. Tennessee (Jeanece)
  - a. Target:
    - i. Shelby (Memphis) and Davidson (Nashville)
    - ii. 50% of all morbidity statewide

- iii. Identified census tracts with high case volume and mapped resources available in/near those areas
    - iv. Majority of cases reported from private sector missing race
  - b. Plan:
    - i. Partner with Memphis CHC near high-morbidity census tract
    - ii. Compare morbidity for census tracts based on facility testing vs. patient residence (e.g. where do people go for services)
    - iii. Implementing PRISM; assist with partner management and monitoring of timely treatment
- 4. Kentucky (Sheri)
  - a. Target:
    - i. Jefferson County (Louisville)
    - ii. “No brainer” – majority of all GC for state in this county
    - iii. African Americans
  - b. Plan:
    - i. Look at screening coverage for family planning visits in seven family health centers
      - 1. 15-19: 78%
      - 2. 20-24: 62%
    - ii. Monitor timely treatment
    - iii. Targeted partner services
- 5. Florida (Adrian)
  - a. Target:
    - i. In draft plan, was Miami-Dade
    - ii. Focus is now statewide, but on special populations and high-morbidity areas
      - 1. Non-Hispanic, African American
      - 2. Youth
      - 3. Pregnant females
  - b. Plan:
    - i. Treatment Action Guidelines
    - ii. Decentralized phone bank
    - iii. Partner services – interview, treatment verification for all CT(?), GC and syphilis for
      - 1. Pregnant females
      - 2. Youth <15 years of age
      - 3. Cases identified in high morbidity census tracts
    - iv. Training for local health departments on using GIS (ARC Publisher, ARC Explorer) to identify high morbidity census tracts
      - 1. State Health Department will develop layers
      - 2. Local Health Departments will use local data to map
- 6. South Carolina (Constance)
  - a. Target:
    - i. Top ten counties for GC cases (big area)
    - ii. Most cases diagnosed in private sector
    - iii. African American males and females
  - b. Plan:
    - i. Reiterated plan laid out in CSPPS
    - ii. Risk reduction counseling

- iii. Increase after hours clinics
  - iv. Public health detailing
  - v. No mapping capabilities at this time
7. North Carolina (Ron)
- a. Target:
    - i. Top ten counties (54% of all GC)
    - ii. Young African American females
  - b. Plan:
    - i. GC disparities memo to local health departments
    - ii. Work to obtain data from the largest five counties that do not currently participate in IPP
    - iii. FP has proposed making CT/GC screening for females <25 a requirement
    - iv. Contact cards
    - v. Outreach workers cross-trained on STD education – could be trained to collect urine specimens
    - vi. Site reviews for monitoring and evaluation
8. Mississippi (David)
- a. Target:
    - i. Hinds County (Jackson)
    - ii. Mapped cases in Jackson in relation to areas schools
  - b. Plan:
    - i. Screening in Jackson public middle and high schools
    - ii. Referrals to Crossroads STD Clinic (the only dedicated STD clinic in the state)
    - iii. Will monitoring screening and positivity in targeted sites
    - iv. Community awareness/engagement efforts (STD fact sheet)

11:30 – 12:15pm      **Utilizing Region IV IPP Prevalence Data to Plan and Monitor GC Action Plan Activities – Exploring Possibilities**

*Kelly Opdyke, Region IV IPP Data Manager*

1. Facilitated discussion related to possible indicators identified based on state updates. [See summary table]
2. Data sub-committee reviewed to identify two to recommend to group.
  - a. # “core” IPP facilities reporting testing and positivity in target areas for at least 3 years
  - b. # GC cases reported in target area annually by age, sex, race/ethnicity, county, zip code, provider [statewide/in target area]
3. Data sub-committee will convene a conference call to discuss further and finalize.

**12:15 – 1:15pm                      LUNCH**

1:15 – 2:00pm      **CDC Epi Update**

*Catherine Lindsey Satterwhite, MPH, National IPP Epidemiologist*

1. Chlamydia cases on the rise
  - a. Increased testing
  - b. Increased reporting
2. Black men have more CT than white women
3. NHANES show health disparities, but not as great as in morbidity data
4. First STD Journal article using IPP data (Linda Gorgos and Catherine Satterwhite)
  - a. Data for 2005-2007 have been standardized across regions

- b. Focused on females aged 15-24 in FP settings
  - c. 1.6% positivity overall; 4.2% for non-Hispanic Blacks
  - d. Numbers reflect NHANES (good sign)
  - e. Considered various selective screening criteria based on age, race, and facility-level positivity
5. Chlamydia Evaluation Initiative (CEI)
- a. Screening coverage assessment
  - b. Measuring impact of screening
  - c. Using existing data in novel ways
  - d. No Region IV states funded
6. IPP data release policy pending
7. Why is race missing from surveillance data?
- a. Federal mandate through OMB does not apply to surveillance data, only to federally funded programs
  - b. Reporting of race is encouraged, but not required

2:00 – 2:30pm **Chlamydia Screening Coverage Assessment**

*Kelly Opdyke, Region IV IPP Data Manager*

1. CT positivity is high throughout Region IV, but estimated screening coverage among females in FP was only about 50% in CY 2008.
2. National IPP priority to assess gaps in screening coverage in order to increase screening among females <26.
  - a. 2 levels of analysis: Title X grantees (statewide) or IPP facilities in GC target areas
  - b. Data requested:
    - i. Age, Race, Ethnicity of users tested and not tested for CT
    - ii. # Service Visits by Age
    - iii. Proportion of users tested for CT by visit type
    - iv. CT positivity by age and visit type
  - c. Additional info requested:
    - i. Challenges related to data collection
    - ii. Current screening criteria
    - iii. Strategies to increase screening among females 15-24
    - iv. Barriers to increasing testing among users who do not receive a pelvic exam
    - v. Possible strategies to overcoming barriers
  - d. Possible data sources:
    - i. FPAR
    - ii. Title X admin/billing data
    - iii. Lab data
    - iv. IPP data
3. Review of preliminary findings for NC and TN (compared estimated screening coverage by visit type with CT positivity for same visit types).
4. Challenges include difficulty accessing data for some providers; inability to report on unduplicated users for each measure; no standard definitions for visit types across grantees (other than initial and annual); difficulty distinguishing PTO clients from those receiving other services; data not routinely collected; limited staff resources to extract data; various data sources difficult to link.
5. Facilitated discussion among FP partners to address challenges, next steps.

**2:30 – 3:00pm Support for Targeted CT/GC Testing**

- Region IV IPP Partnership with GenProbe  
*Pete Kelly, Region IV GenProbe Representative*
  1. Great opportunity; Pete is “good at selling things related to public health”
  2. Long history partnering with Region IV; Region VI replicated some efforts
  3. Over the last year, coordination of states efforts has been fragmented
  4. Call for coordinated regional proposal for states’ needs for free test kits
  5. Pete receptive to expanding to additional sites beyond HBCUs
  6. Suggestions for other types of facilities that may be targeted (especially as part of GC action plans or other efforts to increase screening coverage):
    - a. Community-based organizations, CHCs, schools, juvenile detention centers, adult jails, military (army), Indian Health Service, Prenatal Clinics, Pregnancy Testing sites.
  7. Developed draft worksheet (see separate attachment) for states to describe current activities partnering with GenProbe, and proposed activities. Would need to quantify number of test kits
  8. Pete would like one request for the calendar year (may include multiple shipment dates)
  9. Group decided proposals would be submitted by February 1, 2010.
  
- Community Based Participatory Engagement Special Project  
*Dawn Middleton, Interim Region IV IPP Coordinator*
  1. Presented opportunity for project areas to apply for funds to conduct a community-based participatory research project in a target area to address CT/GC health disparities.
    - a. CBPR informational webinar held Oct. 1, presented by Dr. Alexandra Lightfoot (UNC). Three states from Region IV participated.
    - b. 1 application already submitted by TN DOH.
    - c. Other states welcome to submit applications by end of October.
    - d. CAI will review applications and select one project area for the CBPR project.

**3:00 – 3:15pm BREAK**

**3:15 – 3:45pm CT/GC Internet Partner Management Strategies**

- *Alabama, Mary Scisney, Alabama IPP Coordinator*
  1. ADPH partner notification background: history, purpose, strategy/tools
  2. Internet raises the need for ADPH to seek more innovative and effective strategies for partner notification
    - a. ADPH develops Internet Partner Notification policy & protocols
      - i. Limitations: STD Division is not authorized to access adult websites for email contact tracing
      - ii. Notification procedure relies on index patient to provide as much information as possible about partner contact information, websites used for contact, physical description, privacy issues related to email addresses, etc.
      - iii. DIS and Program Managers responsible for IPN
      - iv. Email and documentation protocol and example notification letter are shared

**3:45-4:00pm Review Agenda for Day 2**  
*Dawn Middleton, Interim Region IV IPP Coordinator*

**4:00pm Adjourn**

**October 9, 2009** [8:30am – 12:30pm]

**8:00 – 8:30am Continental Breakfast [available all morning]**

8:30 – 9:30am

**Regional Business**

- IPP Clinical Guidelines

*Constance Perkins, Chair Region IV IPP Advisory Board and Edecia Richards, Regional Program Director*

1. Advisory Board to begin discussing revisions to regional Clinical Guidelines at next meeting. Constance/Edecia will be responsible for collating revisions and submitting draft to Dr. Geisler (expert medical consultant for R4 IPP) for approval.

- IPP Website

*Cassandra Malone, CAI Director Center for Capacity Development*

1. Call for website items and updates. States can email requests to CAI.

- Follow-up to CDC NACHC Meeting

*Cassandra Malone, CAI Director Center for Capacity Development*

1. 2-day meeting convened by National Association of Community Health Centers and CDC/DSTDP with representatives from FL, LA, MS, SC, TN.
2. Purpose: To examine how CHCs and HDs (state and local) can strengthen relationships with each other and national organizations, and partner to improve the overall health of their communities. Strategies centered on integration of STD prevention and management within primary care system to reduce CT & GC prevalence, but could be applied to other health issues.

9:30 – 10:15am **Laboratory Update**

- CDC Laboratory Guidelines Consultation

*Dean Willis, Florida Department of Health Bureau of Labs*

1. Expert consultation meeting held at CDC (Jan. 13-15, 2009).
  - a. Experts included PH lab directors, STD program directors, STD clinicians, STD lab researchers, FDA and CMS
  - b. Target audience: lab directors, technicians, clinicians, disease control personnel
  - c. Focus: revisions to 2002 “Screening Tests to Detect *Chlamydia trachomatis* and *Neisseria gonorrhoeae* Infections”
  - d. Performance Characteristics:
    - i. All culture and non-culture tests may generate false positives
    - ii. NAATs – superior performance
    - iii. Culture still useful in some situations (GC susceptibility testing, detect mutant strains)
    - iv. When to use serology, Direct detection of LGV (NAATs, homebrew assays)
    - v. Need for more data: LGV specific tests, length of time newer NAATs will remain positive, performance of NAATs with ocular specimen
  - e. Screening Applications
    - i. Vaginal swabs optimal specimen type for use with NAATs
    - ii. Urine for males
    - iii. NAATs superior to culture for detection of rectal CT/GC (not FDA approved for rectal yet)
    - iv. NAATs superior to culture for detection of pharyngeal GC

- v. Can pool specimen for testing with NAATs to reduce cost without compromising performance
  - f. Laboratory Confirmation
    - i. Routine repeat testing of NAAT positives not recommended for CT; repeat testing of positives not recommended for GC unless cross-reaction with non-gonococcal *Neisseria* species results in significant number of false-positives.
    - ii. Medico-legal issues
  - g. Next Steps
    - i. Meeting summary posted to APHL website
    - ii. Lab guidelines due out in early 2010
- Laboratory Hot Topics  
*Richard Steece, PhD, National Chlamydia Laboratory Coordinator*
    1. Public Health Lab History, Mission, Core Functions (disease prevention, control, surveillance)
    2. New CT/GC Tests
      - a. Abbott RealTime CT/NG
      - b. BD ProbeTec CT Amplified DNA Assay
      - c. BD ProbeTec GC Amplified DNA Assay
    3. Future CT/GC NAAT Tests
      - a. HandyLab
      - b. Cepheid
      - c. GenProbe
      - d. Others
    4. Public vs. Private Labs

**10:15-10:30am**                    **BREAK**

10:30 – 11:30am                **Subcommittee Meetings** [Clinical, Laboratory, Data]

11:30 – 12:00pm                **Subcommittee Reports**  
*Subcommittee Chairs*

12:00 – 12:30pm                **Planning Spring 2010 Meeting** [Date, Location, Agenda Items]  
*Cassandra Malone, CAI Director Center for Capacity Development*

1. Fort Lauderdale, FL selected as site for May 2010 meeting
2. CAI will work with Executive Committee to develop agenda and email request for agenda items

**12:30**                                **Adjourn** and Meeting Evaluation [Box lunch]