

Region IV Infertility Prevention Project (IPP)
 Advisory Board Meeting, November 4-5, 2010 – Charlotte, NC

Title: Region IV IPP Fall 2010 Advisory Board Meeting
Date: Thursday, November 4, 2010 – Friday, November 5, 2010
Location: Blake Hotel, 555 South McDowell Street, Charlotte, NC 28204

Participants:

State	Name	Affiliation	STD	FP	Lab	Other
AL	FLEETWOOD HINES	ADPH			✓	
AL	ELIZABETH NICHOLS	ADPH		✓		
AL	MARY SCISNEY	ADPH	✓			
FL	MARGARET RANKIN	FL DOH		✓		
GA	LINDA ALLEN-JOHNSON	GA DHR			✓	
GA	LYNDOLYN CAMPBELL	GA DHR		✓		
GA	LYNETT POVENTUD	GA PH LAB			✓	
GA	MICHELLE ALLEN	GA DHR	✓			
KY	WILLIAM BAKER	KY DPH			✓	
KY	DEBRA ISRAEL	KY DPH		✓		
KY	SHERRI WHITE	KY DPH	✓			
MS	DAVID PEYTON	MSHD	✓			
MS	GWENDOLYN ALEXANDER	MSDH		✓		
MS	CHANEY WALTERS	MSDH			✓	
NC	MARY NOEL DODD	NC DHHS			✓	
NC	CHERYL KOVAR	NC DHHS		✓		
NC	RON HIGGINBOTHAM	NC DHHS	✓			
SC	BRENDA HASTIE	SC DHEC			✓	
SC	CONSTANCE PERKINS	SC DHEC	✓			
SC	BETH DESANTIS	SC DHEC		✓		
TN	SUSAN BARBER	TN DOH		✓		
TN	JIM GIBSON	TN DOH			✓	
TN	MICKEY MCCOWEN	TN DOH	✓			
SD	RICK STEECE	NCLC				✓
CAN	DIONNE GESINK	UNC WORK GROUP				✓
NC	PETER LEONE	UNC WORK GROUP				✓
MS	RITA GORDON	JACKSON HINDS CHC				✓
NC	RENEE FERRARI	UNC – SHEPS				✓
NC	ERIN MCCLAIN	UNC – SHEPS				✓
GA	PATTI BUNYASARANAND	CICATELLI ASSOC.				✓
GA	CASSANDRA MALONE	CICATELLI ASSOC.				✓
GA	GINA MARTIN	CICATELLI ASSOC.				✓
NY	KELLY OPDYKE	CICATELLI ASSOC.				✓

Region IV Infertility Prevention Project (IPP)

Advisory Board Meeting

MEETING MINUTES

Meeting Objectives

1. Discuss national updates and policies, including 2010 CDC STD Guidelines, Health Care Reform and its potential impact on IPP, and Lab updates.
2. Review regional data focusing on GC health disparities, and consider the potential to use new disease mapping strategies and technology to identify and address core networks, enhance surveillance and screening efforts, and reduce transmission.
3. Assess CT Screening Coverage and Guidelines in Family Planning clinics across Region IV.
4. Share updates of innovative IPP initiatives and activities throughout Region IV including CBPR, juvenile detention center screening, Medicaid/HEDIS data, and FP-CHC partnership screening.
5. Discuss agenda and expectations for Spring 2011 Bi-Regional meeting with Region VI.

Day 1

8:00 – 8:30 am **Registration & Continental Breakfast (provided)**

8:30 – 8:45 am Welcome, Introductions, Overview of Agenda
Cassandra Malone (CAI-ATL), Patti Bunya (CAI-ATL), Constance Perkins (R4IPP AB Chair)

1. Announcement: new AB chair to be selected during this meeting.
 - a. The region voted unanimously to name Margaret Rankin (FL DOH) new AB Chairwoman.
 - b. Ron Higginbotham remains AB co-chair (NC DHHS).
 - c. Clinical Subcommittee Chair position will be filled by Cheryl Kovar (NC DHHS).

Data Subcommittee Chair position will be filled by Mary Scisney (AL DPH).

8:45 – ~~9:45~~ am Lab Update: New CT/GC Tests, LOCS Advisory on CT/GC NAATs Reporting
9:15 am *Richard Steece, PhD (National IPP Lab Consultant)*

1. Overview of Public Health Lab History, Mission, Core Functions (disease prevention, control, surveillance)
2. New test technology
 - a. NAAT Advantages & Disadvantages, Performance Characteristics
3. CDC Laboratory Guidelines currently under review, to be released “soon.” Anticipated release: Spring 2011 (tentative)
 - a. Guidelines will recommend **vaginal swab** as optimal specimen type for use with NAATs (patient-collected preferred over clinician collected).
 - i. 4% - 5% higher sensitivity than urine.
 - b. Syphilis testing guidelines will also be included.
4. Laboratory Outreach Communication System (LOCS) Advisory Letter disseminated this Fall.

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- a. Not supported by data
- b. Forthcoming Lab Guidelines will address the issue of re-testing low positives
5. Point of care tests available for CT/GC.

9:15 – 10: 00 am CDC Update (as presented by Steve Shapiro to Region II, Oct. 21, 2010)
Kelly Opdyke (CAI-NYC)

1. Overview of IPP Budget and Funding
 - a. Funding decreasing or steady since 2005
 - b. CSPA 2011 – Additional funds available: National Chlamydia Coalition, Infrastructure shortfall, “Future of IPP” project, additional Project Area Funds (supplemental to CSPA 2011)
2. CDC DSTDP Updates
 - a. Personnel changes
 - b. “Winnable Battles”: Tobacco, Motor Vehicle Safety, Nutrition; Health Care Associated Infections; **Teen Pregnancy Prevention & HIV**
 - c. Summer Consultations
 - d. STD Lab Guidelines (www.cdc.gov/std/treatment/2010/)
 - e. EPT Tools (www.cdc.gov/std/ept)
 - f. LOCS
3. Current State of IPP
 - a. Division Priorities related to IPP: Prevention of STD-related infertility; Prevention of STD-related adverse outcomes of pregnancy; Strengthen STD prevention capacity and infrastructure; Address health disparities.
 - b. Project Area goals and accomplishments; strengths and weaknesses
 - c. Infrastructure goals, activities, accomplishments, strengths, weaknesses
 - d. Key Issues: performance improvement, Affordable Care Act, National HIV/AIDS Strategy
4. Health Care Reform Impact Assessment Project – FY2011
 - a. What does HCR mean for CDC and for STD prevention?
 - b. Future of IPP
5. Gonorrhea
 - a. GC not increasing...may be decreasing (but not in all areas)
 - b. National trends suggest slight decline in case rates
 - c. Higher GC rates reported for several states in MMWR week ending October 9, 2010
6. STD Treatment Guidelines
 - a. Overview of preliminary language in STD Treatment Guidelines revisions for 2010 – primarily strengthening and clarification of 2006 language.

~~9:45 – 10:15 am~~ GC Health Disparities: Region IV Indicators

10:00 – 11:00 am *Kelly Opdyke (CAI-NYC)*

1. GC Action Plan: State Updates
 - a. TN: Target areas – Memphis/Shelby County, Nashville/Davidson County
 - i. Memphis has one of the highest rates for GC nationally, but recent data shows a downward trend in target areas.
 - ii. Typically rates for men are higher, but now rates for women are higher – unsure why.
 - iii. TN DOH is able to run data reports for prison screening

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- iv. TennCare mandates CT screening; TN DOH has been unable to add GC to screening guidelines.
 - v. EPT is legal for CT – not for GC. This would require legislation.
 - vi. CBPR project with St. Andrew AME Church focused on targeting GC. More information is needed from private providers. TN DOH is working with medical director to send out a newsletter to providers to increase awareness and education about GC and screening criteria.
 - vii. Juvenile Detention Center screening approved; screening anticipated to begin March/April 2011.
- b. SC:
- i. Decrease in GC – down by 1338 cases between 2006 – 2009 (BUT increase in Anderson)
 - ii. Increase in cases among AA and 15-20 year olds statewide and in target areas.
 - iii. Lost one target area (Charleston) due to decreased staff.
 - iv. More GC found in private sector than in public sector. HBCU screening is targeted by Div. STD Prevention.
 - v. No EPT, but using DIS-delivered therapy.
 - vi. Increase in Unknown race (race/ethnicity not reported or omitted).
- c. NC: Target areas – 10 counties
- i. Slight increase in GC
 - ii. DHHS memo sent to each county informing Health Directors, Directors of Nursing, etc of GC Action Plan [Ron will share memo].
 - iii. EPT permissible; DHHS in process of developing workgroup to pursue Board of Pharmacy clearance.
- d. MS:
- i. Decrease in GC among all counties and populations; decrease in Hinds County and 2 other target areas.
 - ii. GC cases identified in colleges and JDCs (but less than CT)
 - iii. Currently working to expand high school screening; beginning development of protocols for high school screening in 8 Jackson Public Schools.
 - iv. Screening partnership implemented with Jackson Hinds Comprehensive Health Center
 - v. EPT legal but not implemented: Board of Nursing has not provided regulations
- e. KY: Target area – Louisville/Jefferson County
- i. Decrease in GC statewide and in target areas
 - ii. Interviewing female partners captures more morbidity (80% partner positivity)
 - iii. Implementing jail screening
- f. GA:
- i. Decrease in GC statewide – possibly due to fewer resources for screening? 2 target sites report funding and personnel issues.
 - ii. GC alert letter sent from districts to private providers, HD listed as resource [Linda will share letter].
 - iii. GC patient interviews (ages 15-24) in STD/FP find approximately 2 partners per case; yields approximately 1.5 positive partners (~78%).
- g. FL: No data (FL DOH STD Division representative not able to attend meeting)
- i. GC Action Plan very localized, difficult to quantify

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1. State is looking to revise plan and identify indicators for evaluation purposes
- ii. State personnel announcement: STD Bureau Chief stepping down; acting Chief – Stacey Shiver.
- h. AL: GC Action Plan updated – 5 target counties (67 county PM data sites)
 - i. Decrease in GC statewide; increase in GC in target areas [data shows decrease; Kelly will review with Mary].
 - ii. Added 8 FQHCs for screening, testing, lab, and treatment services.
 - iii. FP requires CT/GC screening for PTO and EC visits.
 - iv. ADPH screens routinely at HBCUs as part of the Healthy Campus 2010 package (provides comprehensive services including FP and Gyn.) and in conjunction with the SPICE project.
 - v. Worked with BCBS of AL to secure payment for CT/GC screening; ADPH expects to see an increase in screening as a result.
 - vi. AL Medicaid (ALL Kids) Quality Improvement committee formed; Mary participates.
 - vii. New Medical Director at state

10:15 – 10:30 am **Break (sandwich snack provided)**

10:30 – 11:00 am GC Health Disparities: Region IV Indicators (cont'd)
Kelly Opdyke (CAI-NYC)

1. Data subcommittee will review and discuss GC Indicators further and make recommendations for reporting.
 - a. Data subcommittee indicated current indicators are sufficient, but acknowledged that not every state is able to report for every component (e.g. cases by provider type, or by zip code)

11:00 – 12:00 pm Core Theory, Spatial Analysis & Geo-mapping Possibilities in Region IV
Dionne Gesink, PhD (U. Toronto), Peter Leone, MD (UNC)

1. Goals
 - a. Enhance existing surveillance systems
 - b. Detect outbreaks of GC, Syphilis (and other STIs)
 - c. Track movement of outbreaks through space
 - d. Examine spatial relationships of sexual & social networks
 - e. Understand core areas – urban & rural
 - f. Examine social determinants of STIs
2. Using geocoding and geomasking to protect confidentiality. Comparison of methods.
 - a. Aggregation vs. Random perturbation vs. Donut method
 - b. NC Syphilis case study overview
3. Core Theory
 - a. San Francisco case study
 - i. 2 syphilis epidemics: Late 1980s (AA), 2000s (MSM)
 - ii. Spikes and valleys of core area trends correspond with non-core areas: Tx in core areas leads to decreased morbidity in non-core areas.

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12:00 – 12:30 pm Group Discussion: Potential & Planning for Core Theory/Spatial Analysis
in Project Areas

1. GA is interested in distinguishing core vs. outbreak populations for syphilis
2. Community partnerships can address underlying issues in core areas (SES, poverty, etc.)
 - a. Focus on the Future (CDC Replicating Effective Programs)
 - b. MS: FP-CHC partnership for screening
3. Tennessee has already identified census tracts in Memphis/Shelby county and is working on developing a proposal for a community-based participatory research project.
4. Next Steps: CAI will debrief with UNC Spatial Analysis Work group and identify Region IV states interested (AL, GA, SC, TN)

12:30 – 1:30 pm **Lunch (provided)**

1:30 – 2:15 pm Spring 2011 Bi-Regional IPP Meeting Overview & Discussion
Cassandra Malone (CAI-ATL), Patti Bunya (CAI-ATL)

1. Regions IV & VI IPP Bi-regional meeting: May 5-6, 2011, Atlanta, GA
2. Bi-regional meeting agenda draft was shared and discussed with the AB.
 - a. Suggestions: Bi-regional subcommittee meetings, pre-meeting evening reception/meet-and-greet, highlight major accomplishments

2:15 – 3:00 pm Regional Business: Website updates, Clinical Guidelines update, Identify
new Advisory Board Chair
*Cassandra Malone (CAI-ATL), Patti Bunya (CAI-ATL), Constance Perkins
(R4IPP AB Chair)*

1. No website updates recommended. CAI will continue to maintain the regional site.
2. Region IV IPP Clinical Guidelines have been revised
 - a. Next Steps:
 - i. Constance will send to Clinic subcommittee for approval.
 - ii. Revised document will then be sent to Dr. Geisler for final approval.
3. The region voted unanimously to name Margaret Rankin (FL DOH) new AB Chairwoman. Subcommittee Chair position will be filled by Cheryl Kovar (NC DHHS). Ron Higginbotham will remain AB co-chair.

3:00 – 3:15 pm **Wrap Up, Review Day 2 Agenda / Break** for AI/AN Work Group

3:15 – 4:00 pm AI/AN Work Group: Development of Regional Screening Assessment Tool
Patti Bunya (CAI-ATL), AL, FL, MS, NC, SC

1. Participants: Mary Scisney – AL
Margaret Rankin – FL
David Peyton – MS
Ron Higginbotham – NC
Constance Perkins – SC
Patti Bunya – CAI-Atlanta
Kelly Opdyke – CAI-NYC
2. Purpose of AI Assessment Tool: to determine 1) What we know, 2) Progress made, and 3) Next steps.

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- a. FL - has no relationship with tribes, no access to data or information beyond what is available through DOH sites. Data is only available if American Indians come to health departments for services.
- b. In general, states lack substantial data on AI – not a priority for states.
- c. SC – Constance has reached out to partner Chris Compher at USET Tribal Epi Center to initiate contact with Catawba Indians.
- d. AL – Mary attended a meeting with Poarch Creek Indians along with 2 IHS representatives (not sure who).
- e. David compiles the list of elements chosen for inclusion in the AI assessment tool.
- f. **Next Steps:**
 - i. Patti will draft a template for states to complete and return by March 31.

4:00 pm Adjourn

Day 2

8:00 – 8:30 am Continental Breakfast (provided)

8:30 – 8:40 am Welcome back

**8:40 – 9:45 am CT Screening Coverage in Family Planning & Population-based Screening
*Kelly Opdyke (CAI-NYC)***

1. Background
 - a. Among females 15-24 in FP, CT positivity is high (10% in Region IV, 2009) but estimated screening coverage is approximately 50%.
 - b. Coordinated effort and National IPP priority across all 10 Public Health Service regions to assess gaps in screening coverage
2. Purpose of assessing gaps in screening coverage
 - a. Establish baseline data describing female FP users who were and were not tested for CT
 - b. Identify gaps and opportunities to increase screening among females <26
3. Preliminary findings
 - a. All 8 project areas able to report on estimated screening coverage by age, gender, and race/ethnicity
 - b. Only GA and TN able to report specifically on number and proportion of PTO users screened for CT; only TN able to report on positivity for PTO clients screened.
 - i. GA: 42% of PTO users were screened vs. 63% of Initial or Annual exam users
 - ii. TN: 54% of PTO users screened vs. 35% of Initial/Annual exam users. Overall CT positivity for PTO users was 6.2% vs. 4.6% for I/A exam users.
 - iii. TN data show high positivity among teen PTO users
4. Challenges
 - a. Unable to report on unduplicated users by visit type
 - b. Only “Initial/Annual” visit type standard across all 8 grantees
 - c. Difficult to distinguish PTO clients from clients receiving other services
5. New approach to assessing screening gaps: Region II IPP Room Study Pilot
 - a. Survey conducted September 2010. 50 patients surveyed over 2 weeks (46 female, 4 male)

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- b. Data were de-identified and contained unique patient numbers
- c. Results: 35 of 50 (70%) patients screened for CT/GC
 - i. 4 of 4 (100%) of male patients screened
 - ii. 31 of 46 (67%) of female patients screened
- 6. Findings & comments
 - a. Project coordinator at pilot site found the tool “easy to use” and had minimal issue separating males from females
 - b. All males only received CT/GC test (male patients may have been partner contacts)
 - c. PTO represented a missed opportunity, although most cases were outside of target age group (>26)
 - d. More information needed to determine what “other services” were provided to clients not tested for CT/GC
- 7. **Next Steps**
 - a. Identify additional project areas/clinics able to participate in room study assessment
 - b. Consider non-FP sites? (ie. CHCs)
 - c. Revised the tool? (if needed)
 - d. IRB considerations (if needed)
 - i. IRB determination can be acquired from CDC (state IRBs may or may not accept)
 - e. -> Is Region IV interested in doing this room study?
 - i. Some confusion was expressed during Sept. 13 conference call around purpose and guidelines for room study: 2 weeks vs. 1 month; mail in all forms or fax daily/weekly?
 - ii. AL interested in looking at the room study tool to see if they can pull the same data from patient encounter forms. Patti will send forms to Mary and Beth.
 - iii. GA: Districts are implementing their own initiatives to increase screening. Lyndolyn will share information about each district’s approach and year end findings.
 - iv. KY will review FPAR data to assess any increased screening and will consider doing the room study.
 - f. Can the room study be included as part of Quality Assurance chart audits? To be explored further.
 - i. Further discussion indicated that QA chart audits are typically limited to clients having an initial or annual exam, which would not include clients attending for other services who would still fit screening criteria

Population-based Screening

- 1. States can indirectly estimate CT screening coverage by using surveillance data to “back calculate” total number of sexually active females that must have been screened to yield the amount of reported CT cases (based on the method outlined by Levine, et al. – see one-page handout)
- 2. Data needed for calculation:
 - a. Female population estimate
 - b. Proportion of sexually active females
 - c. Number of females with at least one (unduplicated) CT case in past 12 months
 - d. Point of prevalence of infection (CT positivity)
- 3. Indirect Estimate of CT Screening Coverage
 - a. *Population at risk = Female population * Proportion sexually active*
 - b. *Number screened = Unduplicated female cases of CT / CT positivity (+/- 95% CI)*

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- c. *Screening Coverage Estimate = Number screened / Population at risk*
- 4. Assuming census data are accurate:
 - a. Factors that can inflate the estimate include:
 - i. Underestimating the proportion of sexually active
 - ii. Underestimating CT prevalence
 - b. Factors that can deflate the estimate include:
 - i. Underreporting CT cases
- 5. Data subcommittee to further discuss using this indirect method.
 - a. The data subcommittee was interested in pursuing this methodology
 - b. Estimates can be updated annually using available data sources

9:45 – 10:00 **Break**

10:00 – 10:45 am Region IV Activity Highlights: CBPR Update (TN), JDC Screening (TN), Medicaid/HEDIS Data (AL), FP – CHC Screening Partnership (MS) *Mickey McCowen (TN), Mary Scisney (AL), Gwen Woodard/Rita Gordon (MS)*

- 1. CBPR Update – Mickey McCowen (TN)
 - a. 38% of Tennessee’s GC burden comes from Memphis-Shelby County
 - b. Six focus groups were conducted (3 male, 3 female). These focus groups highlighted a general lack of community knowledge about GC, infertility outcomes, and antibiotic resistance.
 - i. Focus group participants indicated that education and awareness efforts for GC prevention and screening should be targeted at middle and high school aged groups, and efforts should include media campaigns and incentives for screening.
 - ii. Participants also suggested identifying a community spokesperson (such as rapper Yo Gotti) to serve as the face of educational media campaigns or awareness events such as St. Andrew AME’s World HIV/AIDS Day.
 - iii. One participant suggested implementing a mandatory testing policy through Medicaid, or a new national guideline through health care reform.
 - c. **Next Steps**
 - i. Writing a proposal for funding to do an education/outreach campaign. Potential funders include Kaiser Family Foundation, BCBS of TN Foundation, and federal agencies.
 - ii. Working with the UNC Spatial Analysis Group to map GC in the Memphis-Shelby County area in order to target outreach activities.
 - iii. Conducting key informant interviews with providers at health centers identified by focus group participants, and providers with high numbers of GC cases.
- 2. JDC Screening in TN – Mickey McCowen (TN)
 - a. This effort has been a priority for the state. They were previously unable to screen in the JDCs (a juvenile court judge feared there would be racial stigma associated with screening).
 - b. Mickey wrote a 3-page letter of justification to the Judge, aides, and the JDC Medical Director demonstrating the need for screening: the Judge agreed to allow screening.
 - c. An MOU was developed between the Memphis-Shelby County Health Department and the JDC.

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- d. It is projected that 4,000 juveniles (male and female) will be screened during the first year (funded through MSCHD).
 - e. TN DOH has been approached by Davidson County (Nashville) to do screening in their JDC.
 3. Enhancing CT Screening in Partnership with the AL Medicaid Agency – Mary Scisney (AL)
 - a. In order for Medicaid data to be reported to HEDIS, the data must be validated. ADPH is currently pursuing funds for this validation.
 - b. Mary approached representatives from BCBS of AL and the AL Medicaid Agency (ALMA) Medical Director to participate in a work group and attend monthly ALMA CT HEDIS/QI meetings. Mary continues to meet monthly with ALMA Medical Director as part of the Alabama Health Care Improvement and Quality Alliance.
 - c. BCBS of AL was recently approved to include CT screening in their PMD preventative services program.
 - d. ALMA provided (unofficial) CT screening coverage data to ADPH in June 2010; Kelly provided TA in analyzing and interpreting the data.
 - e. Lessons Learned include:
 - i. Difficulties in comparing HEDIS measures to non-HEDIS (“HEDIS-like”) measures
 - ii. Administrative claims data alone is not sufficient as an indicator of health quality
 - f. Next Steps:**
 - i. Distribute provider bulletins with CT Screening and Tx Guidelines
 - ii. Ensure universal recommendations in ALL Kids for CT screening
 - iii. Draft a Quality Improvement article and related chapter for inclusion in Medicaid Manual
 - iv. Continue monthly meetings with ALMA
 - v. Pursue funding to validate HEDIS measures
 - vi. Consider a special project to increase screening among Medicaid providers region-wide
 4. Enhancing CT Screening Through Partnership with a Community Health Center – Gwen Alexander-Woodard (MS) & Rita Gordon (Jackson-Hinds CHC)
 - a. Overview of high rates of CT and GC in Hinds County, MS
 - i. MS ranked #1 nationally in CT case rates in 2008; high prevalence among 10-19 year old African American females
 - ii. MS ranked #1 nationally in GC case rates in 2008; 30% of GC cases from 10-19 year olds; high prevalence among African Americans.
 - b. Goals for partnership funded by OPA
 - i. Expand CT/GC screening, testing and treatment in female patients according to CDC recommendations (increase screening 5% in Year One; increase screening 15% in Year Three)
 - ii. Reduce CT/GC infections by providing prevention counseling and health education to 100% of female patients age 15-26.
 - c. Jackson Hinds Comprehensive Health Center chosen as community partner for enhanced CT screening funds. 7 services sites in Hinds, Warren and Copiah Counties participate in the partnership to provide CT/GC screening to 1500 women age 15-26. JHCHC sees 3000 Women’s Health patients per month, which exceeds the funding capacity to screen; some patients are not able to be tested.
 - d. JHCHC has been added as an IPP prevalence monitoring site in MS.

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- 10:45 – 12:15 pm** Subcommittee Break Outs
- 12:15 – 12:30 pm** Subcommittee Report & Wrap Up
- 12:30 pm** **Adjourn (Deli Box Lunch provided)**