



Region IV & Region VI Bi-regional IPP Meeting  
Clinic Subcommittee Agenda & Summary Notes

Subcommittee Chairs:

Cheryl Kovar, NC DHHS

Margie Montoya, NM DOH

Participants:

Beth Nichols, AL

Sharon Ashcraft, AR

Margaret Rankin, FL DOH

Marie Jose Francois, FL CHC

Lyndolyn Campbell, GA

Kimberly Brown, GA

Debra Israel, KY

Gwendolyn Woodard, MS

Ann Benson, OK

Susan Watts, SC

Susan Barber, TN

Mary Cullinane, TX

Alicia Nelson, TX

Renée Ferrari, UNC-Sheps

Edecia Richards, DHHS Region IV

Dawn Middleton, CAI (Region IV)

Patti Bunya, CAI (Region IV)

Allison Atterberry, CHT (Region VI)

**I. Introductions**

**II. Discussion: How is IPP implemented in your state?**

- In TX, FP and STD split CSPS funds 50/50 – this is a component required by the grant. The lab is also given funding for testing supplies and medication.
- In GA STD division buys all supplies for the 30 IPP sites. State law requires screening of all women <29 years old.
- NC does not charge for STD testing and treatment – except for men. Men are not eligible to be screened due to funding criteria (screening for women is the priority).
  - o IPP covers about 1/3 of testing; the rest is billed to Medicaid by the Lab.
  - o 5 counties do not participate (counties in NC are independent entities); data collection from these counties is a problem. They are required to report positives, but do not report much else. The Medical Director thinks the state can begin to collect other data.
- FL collects data statewide through PRISM. Funding goes directly to STD programs and counties get billed for tests used.
  - o FP tries to bill insurance if possible rather than use the public health lab
  - o Private providers also report through PRISM
  - o Pregnancy test and Emergency Contraception clients are screened, and FL DOH provides preconception health counseling for women under 25.



- Family Planning waiver – all states have.
  - o SC is able to provide services and bill for males through Medicaid.

### III. Chlamydia/Gonorrhea

#### a. Testing criteria in FP & STD clinics

- Retesting at 3 months: are return visits coded as FP or STD?
  - FL CHC has 1 code for FP and STD visits

#### b. Testing modalities: Endocervical, vaginal (self/clinician collected), urine

- NC is moving to all self-collected vaginal tests to be used in public health clinics (lab is currently ordering only these types of test kits). This change was motivated by information passed down through IPP.
- NM not using a lot of vaginal tests yet – mostly endocervical and urine.
- TX still performing a lot of urethrales on males.
  - TX contracts all FP and STD services. Sites have independent MDs.
- AL sees a lot of urethral testing in Jefferson County (Jefferson and Mobile counties are more autonomous from the state).

### IV. Partner Education/Training

#### a. How is IPP information disseminated to the delegate clinics and other partners in your state?

- CHC has a Title X Information & Education Committee which includes partners from jails, FBOs and community members.
- Title X Guidelines revision update: Cheryl is on the NFPRHA committee.

#### b. How do you bring delegate clinics and other partners “up to speed” on relevant new clinical changes (ie. Pap/pelvic exam, CT/GC testing, etc.)?

- i. Is this an important link in your state in partner education?
- ii. How do we know we are being effective in our trainings?
  - (No comments)

### V. Health Disparities

#### a. What steps are being taken to address health disparities in your state/region?

- (No comments – addressed in general meeting notes)

### VI. EPT – further discussion if necessary

- (No comments – addressed in general meeting notes)

### VII. Expanded Role Nurses

- GA and SC employ expanded role nurses. GA is looking at how to certify these expanded role nurses; will begin collaborating with three schools to offer the needed courses. GA is not anticipating changes related to Health Care Reform / Affordable Care Act, which indicated the public sector will not be providing as many direct services.

### VIII. Public Health after Health Care Reform

- It is anticipated that public health clinics will still need to provide safety net services.



- KY sees the need for billing and reimbursement and does have some very proactive counties, but other counties with large low income populations don't see the need to bill (majority of clients are on Medicaid or are uninsured).
- FL: decisions to coordinate/establish billing services are made at the county level.