



## **Region IV & Region VI Infertility Prevention Project Bi-Regional Advisory Board Meeting**

Thursday, May 5 – Friday, May 6, 2011  
Renaissance Hotel Midtown Atlanta (formerly Hotel Palomar)  
866 West Peachtree Street NW  
Atlanta, GA 30308  
678-412-2400

### **MEETING OBJECTIVES**

- 1. Engage IPP and STD leadership to consider implications of the Affordable Care Act and Health Reform on the Infertility Prevention Project nationally and regionally, including the potential need to forge new community partnerships and establish new roles and responsibilities for public health in continuing to support activities to promote gonorrhea and chlamydia health equity.**
- 2. Review, compare and contrast regional epi profiles and service delivery systems for Region IV and Region VI.**
- 3. Share and discuss bi-regional efforts to promote targeted screening and treatment services to communities disproportionately affected by Ct/GC including: use and application of EPT, and school-based screening.**
- 4. Engage and empower project areas around opportunities and challenges associated with addressing health disparities and providing effective services in times of limited resources.**

### **MEETING AGENDA & SUMMARY NOTES**

#### **Day 1: Thursday, May 5, 2011**

- 8:00 – 8:30 am**      **Registration & Continental Breakfast (provided)**
- 8:30 – 8:45 am**      Bi-Regional Welcome and Introductions  
*Bi-regional Advisory Board Chairs: Margaret Rankin, Ron Higginbotham, Dan Burke*
- The bi-regional Advisory Board/Committee Chairs opened the meeting and welcomed the regions, guests and speakers. Participants stood to introduce themselves.
- 8:45 – 9:00 am**      Meeting Purpose  
*Region IV & Region VI Infrastructures*
- The Region IV and Region VI Infrastructures restated the purpose and significance of the bi-regional meeting as an opportunity to share activities and ideas around addressing the similar burden of disease and health disparities between Regions IV and VI.
- 9:00 – 10:00 am**      CDC Update  
*Steve Shapiro, National IPP Coordinator, CDC*
- ➔ **See [CDC Update\\_Shapiro Presentation](#)**



- Overview of CSPS funding. Future funding is uncertain based on current legislation.
- Project areas should submit draft CSPS applications to Infrastructures with enough time to incorporate comments and revisions by August 2, 2011 deadline.
  - o Emphasis should be placed on epi and prevalence data.
  - o CSPS requirement for project areas: include line item travel budget for STD program manager or other decision maker to attend National STD Prevention Conference (Minneapolis, MN | March 2012).
- Lizzi Torrone will transition into Catherine Satterwhite's position; data-related issues and questions should be directed to Lizzi.
- The future of STD prevention: Assurance, Policy Development, Assessment and Accountability
  - o Programs and planning will be data-driven.
  - o EPT adoption/implementation and ensuring billing/reimbursement capacity are priorities.
- Review of national Ct and GC rates and trends
- STD Treatment Guidelines update
  - o New recommendations for treatment of uncomplicated gonorrhea
  - o Chlamydia screening for men in high prevalence clinical settings should be considered if resources permit and do not hinder efforts to screen women.
  - o Retesting for Ct and GC recommended 3 months after treatment.
    - Research being conducted at Yale around genotype testing.
- Is gonorrhea decreasing? (Source: NETSS Data, CY 2009 – CY 2010)
  - o ↓ KY (1%), NC (2%), FL (3%), SC (3%), OK (8%), TN (10%), GA (11%), MS (22%), LA (32%)
  - o ↑ AL (5.4%), AR (7%), TX (8.5%), NM (16%)
    - May 16, 2011 CDC-PTB webinar: "Update on Gonorrhea Morbidity Trends and the Programmatic Response from Select SSuN Sites"

**10:00 – 11:00 am** National Laboratory Update

*John Papp, CDC LRRB*

➔ See **CDC Lab Update\_Papp Presentation**

- Overview of key updates to 2011 CDC Lab Guidelines for chlamydia and gonorrhea
  - o Anticipated release date: late summer / early fall 2011 in MMWR
    - For females, vaginal swab is optimal specimen type for NAAT.
    - For males, NAAT for urine.
    - Routine repeat testing for positive NAATs not recommended.
- Overview of APHL / CDC STD Steering Committee priorities and activities
- Discussion around how to effectively disseminate information and resources to the field
  - o CDC
  - o Infrastructures
  - o STD/HIV Prevention Training Centers (PTCs)
  - o CHT resource: multi-regional tool kits could be shared



**11:00 – 11:15 am      Break**

**11:15 – 12:00 pm      Bi-Regional Epi Profile**  
*Sarah Goldenkranz (CHT) and Kelly Opdyke (CAI)*

➔ See **Bi-regional Health Disparities Data\_Goldenkranz&Opdyke Presentation**

- Comparison of Region IV and Region VI
  - o Lab test and specimen type
    - **PRIORITY:** Increase use of urine for males (decrease use of urethral specimens) and vaginal swabs for females.
  - o Ct and GC testing and prevalence by sex, age, race/ethnicity, facility type and by state
- Description of health disparities in Ct and GC positivity by state
  - o Most affected populations: African American females ages <26, especially teens 15 – 19.
    - **PRIORITY:** Target screening efforts around younger populations and those most at risk.
  - o Strategies and opportunities to ensure health equity
    - Resources and informational articles provided

**12:00 – 1:00 pm      Lunch (provided)**

**1:00 – 3:00 pm      Health Care Reform, Health Disparities & Advocacy Workshop**  
*Bill Smith, Executive Director, NCSD*

➔ See **HCR, Disparities & Advocacy\_Smith Presentation**

- Overview of NCSD, STD funding trend, impact of decreased funding on state/local program capacity and services
- Populations at greatest risk for STDs
  - o Youth (ages 15 – 24)
  - o MSM
  - o Racial/ethnic minorities (especially African Americans)
- Impacts of Health Care Reform (HCR) and key issues
  - o STD-related preventative services “covered” by insurance
  - o USPSTF grades
  - o **\*BILLING CAPACITY\***
  - o New providers and quality assurance; confidentiality
- State and local HDs need to engage in advocacy, especially around HCR issues.
  - o Family Planning is better prepared for HCR than STD.
- Affordable Care Act (ACA)
  - o ACA is promising, but safety net services must remain available
  - o Public health role will shift to surveillance activities
  - o Other issues to consider:



- Lessons from Massachusetts
- Rural health care and prevention
- Role of nonprofit providers
- Training new providers
- Opportunities for IPP
  - Need to redefine IPP. 3% positivity is critical.
- Need to integrate sexual health into comprehensive health care delivery and prevention services.
- Program Collaboration and Service Integration (PCSI): IPP was PCSI before PCSI was PCSI.
  - Aims to maximize public health impact through linkages between programs to facilitate service delivery.
- To become an associate member of NCSDDC, email [kmayor@ncsddc.org](mailto:kmayor@ncsddc.org)
- Next NCSDDC Annual Meeting: November 1 – 4, 2011; San Diego
- Project Area activity: state IPP partners worked together to come up with three reasons IPP is important and/or what IPP accomplishes. Goal was to create a list of key points to address if/when speaking to members of Congress. Each state reported on their three points; states were encouraged to contact their state/US representatives and advocate a sexual health platform or do at least one thing related to advocacy, education, or awareness in the political arena. Activities will be followed up upon at the next regional meeting.

**3:00 – 3:15 pm**      **EPT Jeopardy Break**

**3:15 – 4:30 pm**      EPT: Region VI successes, challenges, lessons learned  
*Mohammad Rahman (LA), Dan Burke (NM), Mary Cullinane (TX)*

- ➔ See **Louisiana EPT\_Rahman Presentation**
- ➔ See **New Mexico EPT\_Burke Presentation**
- ➔ See **Texas EPT PSA Video**

**4:30 pm**      **Review Day 2 Agenda & Adjourn**  
*Bi-regional Advisory Board Chairs: Margaret Rankin, Ron Higginbotham, Dan Burke*

**Day 2: Friday, May 6, 2011**

**8:00 – 8:45 am**      **Continental Breakfast (provided) and Check Out**

**8:45 – 9:00 am**      Welcome Back  
*Bi-regional Advisory Board Chairs: Margaret Rankin, Ron Higginbotham, Dan Burke*

**9:00 – ~~9:30~~ 10:00 am** Director's Remarks  
*Gail Bolan, Director STD Prevention Division, CDC*

- See **IPP Past, Present, Future Direction\_Bolan** Presentation
- History of IPP, collaboration between FP, STD, and PH Lab
    - IPP initially designed to deliver STD prevention through family planning services; now includes partnerships (Indian Health Services), coalitions (National Chlamydia Coalition), and social media campaigns (Get Yourself Tested). Goal is to provide comprehensive, integrated STD services.
    - CSPS structure
      - Final year of CSPS (2013) will not require collection of performance measure data. CDC will distribute letter of notification.
  - IPP Accomplishments, DSTDP Priorities, Future Strategic Priorities
  - Gonorrhea: #1 health disparity in the nation. How can we address the disparities?
    - Social and structural approaches to prevention:
      - Community mobilization
      - Integration of STD services
      - Policy interventions
      - Contingency funding
      - Economic and educational interventions
      - Promoting science on disparities
  - Need to anticipate changes in the health care system and become more familiar with health care legislation.
    - More people will have insurance coverage; Medicaid expansion
      - Opportunities to collaborate with Medicaid to improve quality of care?
    - Expansion of CHCs and role as primary care providers for priority STD populations; potential for collaboration?
    - Investment in Health Info Technology
      - Current emphasis on electronic laboratory reporting capacity. Surveillance moving away from STD\*MIS toward newer NETSS-based system or PRISM.
  - Importance of ensuring access to care. Public health will focus less on service delivery, but direct services will still be needed as part of the safety net for populations not able to access care elsewhere.
    - Realigning staff so they are “fit for purpose.”
    - Assessment and Assurance that IPP activities are implemented on a population level.
  - Importance of identifying components of HCR legislation relevant to STD, FP and RH programs; integrating public STD and FP clinics into the medical home; billing for services while maintaining confidentiality, including on Explanation of Benefits.
  - Role of STD/FP Programs
    - STD surveillance
    - Facilitate partnerships/collaborations between STD programs and providers serving at-risk populations (training, TA)
    - Assessment of performance and program impact



- Assure quality STD prevention/FP services for at-risk populations
- Monitor access to health care and identify safety net needs
- Create STD/FP specialty clinics as part of the medical home
- Establish reimbursement mechanisms for STD/FP services
- Upgrade IT systems
- DSTDP will work closely with OPA, HRSA and other sister agencies. DSTDP will acquire part of Division of Adolescent and School Health.

**9:30-10:00-10:30 am** Partnerships with CHCs/FQHCs

*Raul Romaguera, Associate Director for Prevention & Care, CDC*

➔ See **Overview of FQHCs\_Romaguera** Presentation

- Background and history
- Consolidated Health Center Program
  - 1100+ health centers and 6000+ clinic sites operating in every state and territory; approximately 48% located in urban areas.
  - Most sites also provide oral health, mental health, substance abuse and pharmacy services.
  - > 18 million patients served in 2009.
  - Current funding: \$2 billion through HRSA (HRRRA); also rely on reimbursement from Medicaid, Medicare, SCHIP, private insurance, self-pay, and state/local/other resources.
- Federally Qualified Health Centers (FQHCs)
  - Created by Congress in 1989; establishes preferential payment policy for health care.
    - CMS manages policy; HRSA determines eligibility.
  - 3 categories for FQHC designation
    - 80%: Grantees under Section 330 of Public Health Service Act (PHSA)
    - 10%: Meet all grant requirements but do not receive grant funding = “Look Alikes”
    - 10%: Centers operated by tribe, tribal organization, or urban Indian organization
  - Required to provide care within federally designated Medically Underserved Area and to medically underserved population.
  - Requirements:
    - Located in (or serve) medically underserved community or area experiencing shortage of PCPs
    - Nonprofit/public/tax exempt status
    - Provide comprehensive quality primary health care services
    - Participate in government insurance programs (Medicaid, Medicare, SCHIP)
    - Use sliding fee scale based on patients’ ability to pay
    - Report key performance measures



- Governed by community board composed of at least 51% patients
- Majority of patients are uninsured or on Medicaid (2009)
  - 2/3 are racial/ethnic minorities
  - 1/7 living below 200% of federal poverty level
  - ¼ are homeless and migrant/seasonal farm workers
- Revenue mix (2007): 37% Medicaid, 29% Other (may include private insurance), 21% Grant, 7% Private, 6% Medicare
- Quality assurance includes HRSA Primary Care Effectiveness reviews, JCAHO accreditation (about 1/3 are accredited), and health disparities collaborative (with IHI)
- Specialty services can be added but must meet guidelines
- TA and QA from Primary Care Associations and State Primary Care Offices
- Partnerships between FQHCs and LHDs for Engaging in the Development of a Community-Based System of Care
  - Developed between NACHC and NACCHO. See report published Oct. 2010  
[http://www.nachc.com/client/Partnerships%20Between%20FQHCs%20and%20LHDs Final 11 03 10%20\(2\).pdf](http://www.nachc.com/client/Partnerships%20Between%20FQHCs%20and%20LHDs%20Final%2011%2003%2010%20(2).pdf)

**10:00 – 10:45 am** Innovations Panel & Discussions  
Partnerships to Enhance Screening (*Mary Scisney, AL*); ~~Charter School Screening~~ (*Jennifer Curtiss, TX*); School-based Screening (*David Peyton, MS*)  
➔ See **Screening Partnerships in AL\_Scisney** Presentation  
➔ See **MSDH High School Screening\_Peyton** Handout

**10:45 – 11:00 am** **Break**

**11:00 – 12:30 pm** Making Tough Decisions with Limited Resources  
*Michelle Gerka, CAI*

- Meeting participants were divided into small groups and given time to read over a scenario. The scenario asked participants to consider how they would divide a sum of money among 4 hypothetical children, each with different financial and personal circumstances.
- Each group was then asked to collectively decide how to divide the “scarce resources” among recipients of varying levels of need. About half of the groups chose to split the money equally among the 4 children; other groups distributed the money based on perceived need. This spurred some passionate reactions and discussion around the difficulties associated with resource allocation and decision-making strategies.
- Participants shared their experiences in working with others who disagreed about how to split the money and related the activity to the reality of making tough decisions about how to allocate limited funds for IPP and STD-related activities.

**12:30 – 1:15 pm** **Lunch (provided)**



**1:15 – ~~2:00~~ 2:30 pm** Bi-regional Subcommittee Breakouts (Clinic, Data, Lab)  
**~~2:00 – 2:30 pm~~** ~~Bi-regional Subcommittee Report Outs (Clinic, Data, Lab)~~  
→ See **Subcommittee Notes** (Clinic, Data, Lab)

**2:30 pm** **Wrap up & Adjourn**