

MEETING SUMMARY
REGION VIII INFERTILITY PREVENTION PROJECT
REGIONAL ADVISORY COMMITTEE MEETING

May 6-7, 2010

The Hotel Monaco, Denver, Colorado

Building Bridges and Finding Common Ground – Collaborating to Improve STD Prevention and Reproductive Health for Region VIII American Indian/Alaska Native Communities – Part II

Focus and Objectives:

The Region VIII Infertility Prevention Project work requires knowledge and skills in dealing with many special populations—schools, prisons, private providers as well as American Indian/Alaska Native (AI/AN) communities.

In focusing this meeting on AI/AN communities, the objectives are as follows:

- Provide an overview on the growing problem of gangs in Indian Country and their potential impact on tribal communities and at-risk youth, particularly in terms of STD prevention efforts.
- Describe and highlight the key reproductive and sexual health disparities among AI/AN populations as compared to other race/ethnicities;
- Highlight successful partnerships that support, advocate, and compliment IPP screening priorities.

However, owing to the limitations of the time constraints in the amount of information that we could address in the day and half together, there are additional resources provided in your packets and listed on a resource sheet so that you may continue to explore the rich and vast history and culture of our AI/AN communities in our region. Additionally, we will have face-to-face opportunities for work groups and state partners to continue to develop plans to address the Region VIII IPP Strategic Plan goals. Within this session of the meeting, the objective is as follows:

- Provide time for state and work group discussions pertaining to priority activities.

This is a face-to-face opportunity for work groups and state partners to continue to develop plans to address both the Region VIII IPP Strategic Plan goals and their own state goals. In addition, there will be an opportunity for the committee as a whole to gain an understanding of that work and to provide feedback to the work groups and state partners on areas of progress where important decisions are needing to be made or where issues may have arisen.



Region VIII Infertility Prevention Project Regional Advisory Committee Meeting

The Hotel Monaco, Denver, CO
May 6-7, 2010

Building Bridges and Finding Common Ground - Collaborating to Improve STD Prevention and Reproductive Health for Region VIII AI/AN Communities - Part II

| Day 1: Thursday, May 6, 2010 | |
|------------------------------|--|
| 8:00 am - 9:00 am | Registration and Continental Breakfast |
| 9:00 am - 9:15 am | <p style="text-align: center;">Welcome Introductions, review agenda & general announcements <i>Yvonne Hamby, JSI</i></p> |
| 9:15 am - 9:30 am | <p style="text-align: center;">Regional Update <i>Lori Nichols, JSI</i></p> |

Notes:
Also see slides

Recap from Fall IPP RAC Meeting

▪ **Overview to Working in Indian Country:**

- Broken into two sessions—(1) Structure of Health Care System for AI/AN, and (2) Tribal Structure and Overview of Tribal Epi-Centers—the goal was to provide a basic framework to assist our Regional Advisory Committee in their work to collaborate with American Indians who live within the various program areas in addressing STD prevention within their community.

Indian Health Service:

- Throughout the United States, the IHS directly operates 31 hospitals, 52 health centers, 2 school health centers, and 31 health stations. In addition, Tribes and Tribal organizations, through contracts and compacts under the Indian Self-Determination and Education Assistance Act, operate almost 50% of the IHS system and provide health care in 15 hospitals, 256 health centers, 9 school health centers, and 282 health stations (including 166 Alaska Native village clinics). The IHS or Tribes/Tribal organizations also operate 11 regional youth substance abuse treatment centers and 2,241 units of staff quarters. In addition, the IHS provides funding for Indian health centers located in 34 urban areas.

Tribal Health Clinics:

- The National Indian Health Board (NIHB) represents Tribal Governments operating their own health care delivery systems through contracting and compacting, as well as those receiving health care directly from the Indian Health Service (IHS).

Urban Indian Health Clinics:

- The range of contract and grant-funded programs listed below are provided in facilities owned or leased by the Urban Indian organization. The IHS is required by law to conduct an annual program review using various program standards of IHS, and to provide technical assistance.
- The range of IHS/Urban grant and contract programs include: information, outreach and referral, dental services, comprehensive primary care services, limited primary care services, community health, substance abuse (outpatient and inpatient services), behavioral health services, immunizations, HIV activities, health promotion and disease prevention, and other health programs funded through other state, federal, and local resources, i.e., WIC, Social Services, Medicaid, Maternal Child Health.
- Tribal Structure and Tribal Epi Centers—3 of the 4 centers are located in Region 8. Tribes have a unique political and legal status that differentiates them from other minority groups. Federally-recognized tribes are sovereign nations.

Update: The IPP infrastructure supported an STD program staff from RMTEC to attend the STD Conference.

▪ **Data And Policy:**

- The session on data and policy highlighted the importance of developing and implementing standards of care and best practices among I/T/U sites through data trends. American Indian and Alaska Native (AI/AN) people are affected disproportionately by many infectious diseases, including human immunodeficiency virus and acquired immunodeficiency syndrome and (HIV/AIDS), sexually transmitted diseases (STDs).
- Because of the sovereign status of tribal governments, tribally-operated health facilities are not tied to the reporting requirements mandated by states. If some health care providers who serve AI/AN clients are not reporting cases to the surveillance system, this would contribute to underestimation of infection and disease prevalence.

Update: Building on the efforts to develop and implement a standard protocol for delivery of STD clinical care in the Phoenix Area IHS, in partnership with the Alaska Native Tribal Health Consortium (ANTHC); IHS National STD Program; JSI Research & Training Institute—Region VIII Infertility Prevention Project (IPP); Project Red Talon, Northwest Portland Area Indian Health Board; and Phoenix Indian Medical Center (PIMC), the Center for Health Training will develop a model protocol and decision tool/flowchart to guide standard delivery of sexually transmitted disease (STD) care to American Indian and Alaska Native (AI/AN) populations at risk for Chlamydia and other STDs.

▪ **Reproductive/STD Health Care and Information Access Points:**

- Provided an overview of the Fort Peck Sexual Health Project. This session addressed where Native men get their STD/sexual health information and what factors influence Native men's intent to use RH/STD services.

▪ **Social and Cultural Issues**

- This session presented an informal overview of general issues around communication (including confidentiality), preferred modes and styles of communication, how to interact; examples of effective communication and prevention messages and strategies, and partnering and collaboration considerations from a cultural perspective.

▪ **Engaging With Native Communities for STD Prevention:**

- Stephanie Craig-Rushing from Project Red Talon provided an overview of her work with the 43 tribal communities in her region to have STD prevention as a health priority and sharing your STD/HIV advocacy kit.

▪ **Small Group Sessions:**

- Two small group sessions were conducted where state and TEC representatives could discuss barriers to collecting, accessing and presenting these data, as well as ways we can work better to reduce STDs in Indian Country. Questions addressed:
 - Who else is currently working with Native communities?
 - What successes have you had that you want to share?
 - What challenges or barriers have you encountered working with AI/AN communities?
 - What do you need to get started connecting to AI/AN in your area?

▪ **Partner Services for AI/AN - Collaborations Between IHS and the South Dakota STD Program:**

- We learned about the various reporting sources for STDs; how partner services are delivered with I/T/U facilities in SD; what works, what could be better for delivering partner services and barriers. Dave mentioned the challenge that gang activity on reservations poses when doing partner services for AI/AN populations.

▪ **Region VIII Participation on Upcoming EPT Consultation:**

- Yvonne/JSI was invited to participate in CDC's consultation on EPT May 12-14, in order to represent the frontier/rural perspective, as well as issues related to EPT implementation in Indian Country. The consultation will focus on:
 - Legal Barriers to Implementing EPT in Practice
 - Liability
 - Regulatory & Licensure Framework
 - Legal and Political Barriers Impeding Adoption of New Laws & Policies Authorizing EPT
 - Identification & Development of Tools to Address Identified Barriers

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| 9:30 am - 12:00 pm | Gangs in Indian Country: An Overview of a Growing Problem <i>Christopher Grant, Native American Gangs Specialist</i> | This session, in two parts, will provide an overview on the growing problem of gangs in Indian Country and their potential impact on tribal communities and at-risk youth, particularly in terms of STD prevention efforts. | Handouts: <ul style="list-style-type: none"> • <i>Gangs in Indian Country: An Overview of a Growing Problem.</i> Christopher M. Grant, M.A., National Native American Gang Specialist • <i>Gang Violence Grows on an Indian Reservation.</i> By Erik Eckholm; <i>The New York Times</i>, December 14, 2009 • <i>Police Chief: Tribal Lands Attract Drug Smugglers.</i> By Roger S. Lucas, <i>The Star Online</i>, December 9, 2009 Resource and display materials: <ul style="list-style-type: none"> • <i>Risky Sexual Behaviors Among a Sample of Gang-Identified Youth in Los Angeles.</i> <i>The Journal Of Equity In Health</i>, November 2009 Vol. 2, No. 1, 61-71 |
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Notes:

- Nationally, there are approx. 26,500 separate gangs. It is the first time in US history what we've had this many criminally-involved gangs, marked by a significant increase in the connectivity between drug distribution and gang activity/violence.
- The average age range for gang members is 13-15 years old.
- There is also an increase in the existence of gangs in smaller communities, including in Indian Country, where it used to be seen primarily in large urban areas.
- Gangster mentality = belief system behind the behavior; the power of this belief system cannot be overstated or overemphasized
- What is a gang? A group with a common name, sign and/or identifying symbol, whose members engage in criminal behavior.
- The 2 primary reasons for the growth/spread of street-gang culture in tribal communities: (1) denial, and (2) minimization
- Street Gang Subculture - Myths and Truths
 - Myth: Real gangs only exist in cities, in certain minority groups
 - Truth:
 - Gangs exist in every size/type of community across the US, and are becoming increasingly prominent in Indian Country
 - Gangs cross every economic, cultural, racial, and ethnic barrier
 - Gangs are increasingly violent and drug-connected
 - Myth: All gang members are juveniles
 - Truth: While it is true that gang members tend to be youths between the ages of 13 and 24, there is activity in people younger than 13, particularly if a family member is already involved, as well as those who are well into their adult years.
 - Some gang members stay involved well in their adult years, and there are multi-generational gang families. Adults tend to be more covert and secretive about their gang behavior. Young members are more open about their involvement, and tend to be more violent—resort to violence to resolve conflict (which is related to the level of emotional development).
 - Myth: Females are not involved in gangs
 - Truth: Many females are associated with gangs: wives, girlfriends, sisters, etc. 10%-15% of gang members are female.
 - Females are just as, and often more, violent and drug-connected as males.
 - Many believe they can get by with the behavior because of their gender; it is true that they are less likely to be searched by law enforcement.
- Ways to join a gang:
 - There is always a form of initiation for new members to prove worthiness. These initiations include “blood in-blood out”—“blood in” means being beaten; “jump in” means being beaten by multiple members.
 - Other ways to join include being born in, blessed in/courted (allowed in without being initiated, such as for younger siblings and family members)
 - Proving worthiness can also include committing a criminal act such as a drug-related act, assault, arson (common in Native American communities), sexual initiation (common for females). The sexual activity, degradation, and exploitation common in gangs means that STDs are a problem in the gang world.

- Females are considered the property of the gang, but males are not bound by this parameter, and males have sexual contacts outside the gang.
- There is often a connection between gangs and school violence.
- The term “wannabe” is a dangerous one - if a person claims, acts, and/or dresses like he/she is a gang member, it is safest to assume it’s true.
- Gang Influences:
 - Gang behavior can be transplanted from one area to another. A tribal member who moves to Denver for a period, and gets involved in a gang, can then move back to the reservation to carry the gang behavior back to the tribe.
 - Gangster rap lyrics have a tremendous influence on gangs.
 - The Internet and other social media are other sources of gang influence.
 - Family dynamics is the most influential factor in gang involvement.
 - Influencing factors in personal dynamics include having a personal void (physical, emotional, mental, etc.) that the gang fills, as well as the allure of gang membership.
- How can health care providers determine whether a patient is gang-involved?
 - Body tattoos, burns, carving, and brands are common signs of gang involvement
 - Specific-color clothing
 - Language/terminology used
 - Providers should ask patients if they are involved in a gang
- Native American gang activity:
 - Began about 10 years ago
 - Escalation over the last 5-10 years, especially in urban centers like Denver
 - Many active gangs in each of the reservations in Region VIII, except for Navajo; the reservations in South Dakota have the most Native American gangs in the US.
 - Gangs on reservations are fighting over scraps, not over money or territory.
- Ways to combat gang involvement/activity:
 - Suppression - law enforcement
 - Prevention - teaching young people gang prevention skills, those that are culturally-oriented tend to work best
 - Intervention - programs that help change the direction that gang members are taking
 - Tribal governments can create gang ordinances; however, there is a general dearth of law enforcement, court, and intervention resources on the reservations.
 - The bottom line is that gangs are a problem common to all communities across the nation, and we are all responsible for addressing that problem.
- Key common prevention points in terms of messages and reach:
 - Can’t make assumptions about risk
 - Target populations are the same for gang risk as STI risk
 - Reasons for engaging in gang or sexual behaviors are the same—love and belonging
 - Schools and parents are important prevention partners

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| 1:00 pm - 2:00 pm | <p>CDC Programmatic Update Steven Shapiro, CDC</p> | <p>This session will provide the national perspective with regard to the Infertility Prevention Project. The purpose of this session is to understand the political climate that may impact funding, and learn about CDC’s priorities in terms of strategies to address Ct and GC. Specifically, staff will respond to questions regarding CSPS/IPP Performance Measures and the PCSI initiative.</p> <p><i>Topics include:</i></p> <ul style="list-style-type: none"> ➤ Upcoming 2010 STD Screening and Treatment Guidelines ➤ Program Collaboration and Service Integration (PCSI)-Update on expectations for programs to adopt and incorporate into their STD programming. ➤ Performance Measure Update ➤ Health Care Reform’s Potential Impact on IPP/STD Programs ➤ Funding and Center/Division Staff Changes ➤ Overview of 2011 CDC IPP Portion of CSPS Applications | <p>Resource and display materials:</p> <ul style="list-style-type: none"> • <i>Program collaboration and service integration: Enhancing the prevention and control of HIV/AIDS, Viral Hepatitis, STD, and TB in the United States.</i> An NCHSTP white paper; 2009 • <i>Improving Clinical Operations: Can We and Should We Save Our STD Clinics?</i> MR Golden, PR Kerndt Sexually Transmitted Diseases; Vol. 37, No. 4, April 2010, 264-265 • <i>Blog: Save the STD Clinics!!</i> By Kees Reitmeijer, March 23, 2010 • <i>2010 Performance Measures Quick Reference Guide</i> |
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Notes:

For the complete CDC Update also see slides

- Budget & funding:
 - State funds for 2010 have been allocated and states have received or will receive shortly
 - Funding added to infrastructure (\$1.2M) for FY 2010 budget for all regions. We still don't know how much we will be getting for spending, or whether it is a one-time allotment, or annual; or what the mechanism for funding will be.
 - Steven asked for the funding picture of each state:
 - ND - (Julie, STD) level funding, no big cuts; fully staffed, as in the past; all federal funding—use some state general funds on some STD meds, but it's not a budget line item allocation
 - SD - (Dave, STD) no furloughs; ODP operates off a combination of funds—have had to reduce STD activities (GC & CT only in certain clinics—IH and FP); they receive some state dollars but it's never clear how much, when, or for what (especially unclear how much can be used for personnel)
 - MT - (Laurie, STD) - no state STD dollars; they pay for meds with federal dollars (for CT med); no furloughs or layoffs, but travel restrictions are in place
 - WY - (Canyon, STD) - no furloughs but there have been 2 retirements without refilling the position; just rec'd some additional state dollars to purchase meds, but most is purchased with fed dollars
 - UT - (Emily, STD) \$700,000 state funding cut, which prompted furloughs; no state funding for STD other than for social marketing program, which they thought was going to be cut, but it hasn't been, and they were told to hire for the one open position for July
 - CO (Kelly, STD) - unable to balance budget for July 2010 FY; furloughs are in place even for federally-funded positions (Steven emphasized that CDC will be taking back those funds), as well as some vacancy savings; state doesn't contribute funding to STD except some for STD meds, but clinics that receive must be certified
 - CO-DPH (Karen) - they also took another big budget hit this year, similar to last year
 - CDC is considering taking back federal funds from states which has state furloughs due to state budget cuts.
- CSPS 2011 cooperative agreement application:
 - There are no changes from previous years of the funding cycle. They are finishing up the guidance, scheduled to be published on June 1 - application due date Aug 2; 3% Ct positivity target is still in place, with appropriate redistribution of funds accordingly (which is clearly defined in the 2009 announcement) and required GC burden calculation.
 - Targeted GC Burden Calculation:
 - GC morbidity burden divided by (GC + CT) morbidity burden in women under 26 [GC+/GC+ plus Ct+ = percent burden applied to IPP funding]
 - Apply that to your IPP dollars and that amount of money has to be used to target GC screening in high morbid areas, up to 10%--all morbidity, regardless of venue. There is a complete definition in the 2009 announcement. There is some flexibility in states with extremely low morbidity as long as you can justify in your narrative, with adequate data.
 - Dave (SD-STD) stated that according to their lab, it would be more expensive for them to take out the CT only results. When they order a test for CT, the system is set up to run both CT and GC. Steven replied that in a "generic" lab setting, the savings is shown to come from not using the GC reagents—there really is no other savings. You can save \$1 to \$1.50 per test by not using those reagents. If you're running 20,000 tests, you're saving ~\$20,000. Also, in a low GC morbidity area, if you use the dual test, you're losing significant specificity because prevalence is so low. Claudia (WY-Lab) replied that it's a single reagent used for both tests—no extra, or different, reagent is necessary. In the Wyoming lab, she is the only staff. There are other Region VIII labs in similar circumstances. The extra costs lie in the additional personnel time that it takes to run separate tests for CT and GC. Steven reiterated that states must decide based on their own circumstances.
 - How can this complicated issue be communicated to the community and to clinicians? It brings up best practice issues. If they shouldn't be screening certain individuals for GC because there are not risk factors, how can that be communicated? Provider education must be provided on both screening guidelines, as well as test interpretations, specific to the prevalence in their area.
 - We are entering the 3rd year of the 3-yr interagency agreement with OPA for the infrastructure. JSI and the other 9 regional partners continue working on describing PTO in the region, as well as health care delivery systems for AI/AN. The final report is due to CDC Nov 2011.
- Leadership changes:
 - Office of the Director
 - Dr. John Douglas, who was the director of the division, took another position within the Center, as CMO for Center for HIV/STD/Viral Hepatitis Prevention.

- Policy Office Director Amy Pulver has taken a 4-mo detail to Washington DC. Mary MacFarlane (GYT campaigns) has taken over, at least temporarily, as Policy Office Director.
 - Epidemiology & Surveillance
 - Director Dr. Stu Berman has gone over to the Center, working on program and quality improvement activities for STD programs, taking over for Dr. Tom Peterman who has been acting in that position since early January.
- Summer Consultations:
 - There are 6 consultations with appropriate subject matter experts planned for this spring/summer:
 - The sexual health consultation took place late April.
 - The EPT consultation is scheduled for May 12-14; Yvonne Hamby will be participating in this consultation.
 - The other 5 consultations are in various stages of development and planning.
- The STD Treatment Guidelines will be published in the fall of 2010. The major change is that dual therapy will be the recommendation for those who test positive for GC on the NAAT but test negative for CT.
- STD CT/GC Lab Guidelines are expected to be published soon, but still in review/revision process. Vaginal swabs will be the specimen of choice for women (but urine & endocervical work just as well); urine swabs are still the specimen of choice for men. NAATs will be the test of choice; retesting to confirm positives will NOT be recommended, unless product insert recommends otherwise, depending on the range of RULs.
- GYT is now Get Yourself Talking and rebranding/relaunching of materials will happen sometime in fall 2010.
- PCSI - The FOA was published last week. The application due date is June 15. None of the states in Region 8 are eligible for this funding because of low morbidity in AIDS, TB, syphilis, GC, and/or HBV.
- Health Care Reform - What does it mean for CDC in general and STD Prevention specifically? The Patient Protection and Affordable Care Act (ACA) of 2010 establishes some mandatory programs, including a prevention and public health fund, eligible to be funded up to \$2B annually by 2015. The funds can be spent on any prevention, wellness, or public health activity authorized in the Public Health Services Act. Because CSPA and IPP are authorized by the PHS Act, we think we will be eligible for these funds, although a lot of the talk that they've heard seems to focus on chronic disease and not infectious disease. The ACA also establishes a National Prevention, Health Promotion, and Public Health Council, but this will be only advisory in nature. Part of their role is to create a national prevention and health promotion strategy, that may or may not be read/heeded. CDC is authorized to create several new programs, but at this time no dollars are currently allocated to these. Another important term of the ACA is that HHS is authorized to allow state access to purchase vaccines at federally-negotiated prices, which is likely much less than the states have been able to negotiate.
- Christine (CO-FP) had her clinics do an audit on CT screenings in patients 26+. It showed that they are doing many IUD insertions; however, the product insert doesn't specify CT screening for IUD insertion; so, if the product insert doesn't recommend it, it is NOT best practice.

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| 2:00 pm - 2:30 pm | State Updates I: Review of AI/AN State Profiles and Updates to Related Activities <i>Colorado, North Dakota, Utah</i> | One of the benefits of regional meetings is to hear about the great work that other states are doing. During this session, each state will report back the progress, successes, and challenges that they have faced in being able to move forward with their action steps with the plan that was developed during the state/small group discussions begun at the Nov 09 meeting. | |
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Notes:

Colorado - At the fall meeting, Colorado IPP partners indicated they would send information about the upcoming application period for Title X funding to Denver Indian Health & Family Services, since they had expressed an interest in becoming a Title X provider, and the IPP partners would read through the state profile and begin discussions/making contacts.

- Status of AI/AN Collaboration:
 - Gathering Information
 - Identifying Other Potential Providers
 - Identifying Current Initiatives
 - Developing list of strategies and activities
 - Building Collaborations
 - What is working? What are barriers?

For more details on the CO update see slides

North Dakota -At the fall meeting, North Dakota IPP partners indicated they would work to enhance the collaborations with the FP program on two reservations, for example the new

FP clinic in Standing Rock. Continue to build the relationships and possibly get IHS to start referring patients there.

- Status of AI/AN Collaboration:
 - Some examples of agencies working with Native Communities include:
 - NDDoH STD, Hepatitis, HIV/AIDS, Immunization, Family Planning, Tobacco
 - Office of the Elimination of Health Disparities
 - Office of Indian Health Affairs

Some successes include:

- Established relationships on each reservation to conduct STD interviews and partner services and data collection
- Health Education Booth at UTTC Pow wow

Some specific projects include:

- Tribal health project STD testing
- Family Planning satellite clinic at Ft. Yates

Challenges encountered:

- Difficult to make referrals when availability of the clinic is limited
- Easier to refer to IHS and flag a chart
- IHS will not fill outside scripts
- Need better communication

For more details on the ND update see slides

Utah - At the fall meeting, Utah IPP partners indicated they would conduct information gathering, link up with HD tribal liaison, bring people together from Indian Walk-in Center to begin discussions.

- Status of AI/AN Collaboration:
 - Collaboration with Urban Indian Walk-In Center:
 The Indian Walk-in Center has multiple programs and are one of the state STD program's HIV prevention contractors. They are working with this clinic on the Ct/GC testing effort. The state STD program staff has been collaborating with Planned Parenthood to offer Ct/GC testing on site in the Indian Walk-in Center, and have also

- been working with them to offer the testing when they go to the reservations and make it an additional service.
- Recent problems with Fort Duchesne nursing/IHS staff turnover, as well as the new data collection system has meant that their AI/AN collaboration efforts have moved more slowly than they intended.
- They have not yet had a chance to try to link up with their tribal liaison. They plan to do this in the near future.
- They will also be doing additional investigation of just how much Ct/GC testing is happening in I/T/U centers. It is not clear, in looking at the data from the tests that the state lab is receiving, whether there may be more testing going on that isn't going through the state lab.

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| 3:00 pm - 4:45 pm | Work Group Discussion - Strategic Plan Goals | This is a face-to-face opportunity for work groups to continue to develop plans to address their Strategic Plan goals. Each work group will report back to the RAC tomorrow afternoon. | |
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Notes:
See report-back summary on Day 2

Day 2: Friday, May 7, 2010

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| 8:00 am - 9:00 am | Executive Committee Breakfast Meeting - <i>Athens Boardroom</i> | | | |
| 9:00 am - 9:15 am | Recap of Day 1 <i>Yvonne Hamby, JSI</i> | | | |
| 9:15 am - 10:00 am | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; background-color: #00b0f0; color: white; vertical-align: top; padding: 5px;"> IHS Update <i>Lori de Ravello, IHS</i> </td> <td style="width: 40%; background-color: #e0f7fa; vertical-align: top; padding: 5px;"> <p>This session is intended to provide a basic framework to assist the Regional Advisory Committee in their work to collaborate with clinics and organizations who serve Urban American Indians who live within the various program areas in addressing STD prevention within their community. IHS will present the national perspective with regard to their efforts toward reducing Ct and GC prevalence in order to identify opportunities to partner and brainstorm solutions to issues around IPP efforts.</p> <p>Topics include:</p> <ul style="list-style-type: none"> ➤ Defining Urban Indian Populations ➤ STD/HIV Performance Measures Initiative ➤ Update on various guidelines/materials: <ul style="list-style-type: none"> ▪ Guidelines for Developing School-based STD Screening Programs ▪ Guidelines for Developing Jail-based STD Screening Programs ▪ Native Stand Curriculum </td> <td style="width: 30%; background-color: #e0f7fa; vertical-align: top; padding: 5px;"> <p>Resource and display materials:</p> <ul style="list-style-type: none"> • <i>Urban Indian America - the Status of American Indian & Alaska Native Children & Families Today</i>. A Report to the Annie E. Casey Foundation by the National Urban Indian Family Coalition • <i>Urban Indian Health, Issue Brief, 2001</i>. Prepared by Ralph Forquera, MPH; The Seattle Indian Health Board for The Henry J. Kaiser Family Foundation • <i>Invisible Tribes: Urban Indians and Their Health in a Changing World</i>. Seattle: Urban Indian Health Commission, 2007 • <i>Visibility Through Data: Health Information for Urban American Indian and Alaska Native Communities</i>. Seattle: Urban Indian Health Institute, 2009 </td> </tr> </table> | IHS Update <i>Lori de Ravello, IHS</i> | <p>This session is intended to provide a basic framework to assist the Regional Advisory Committee in their work to collaborate with clinics and organizations who serve Urban American Indians who live within the various program areas in addressing STD prevention within their community. IHS will present the national perspective with regard to their efforts toward reducing Ct and GC prevalence in order to identify opportunities to partner and brainstorm solutions to issues around IPP efforts.</p> <p>Topics include:</p> <ul style="list-style-type: none"> ➤ Defining Urban Indian Populations ➤ STD/HIV Performance Measures Initiative ➤ Update on various guidelines/materials: <ul style="list-style-type: none"> ▪ Guidelines for Developing School-based STD Screening Programs ▪ Guidelines for Developing Jail-based STD Screening Programs ▪ Native Stand Curriculum | <p>Resource and display materials:</p> <ul style="list-style-type: none"> • <i>Urban Indian America - the Status of American Indian & Alaska Native Children & Families Today</i>. A Report to the Annie E. Casey Foundation by the National Urban Indian Family Coalition • <i>Urban Indian Health, Issue Brief, 2001</i>. Prepared by Ralph Forquera, MPH; The Seattle Indian Health Board for The Henry J. Kaiser Family Foundation • <i>Invisible Tribes: Urban Indians and Their Health in a Changing World</i>. Seattle: Urban Indian Health Commission, 2007 • <i>Visibility Through Data: Health Information for Urban American Indian and Alaska Native Communities</i>. Seattle: Urban Indian Health Institute, 2009 |
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Notes:
For the complete IHS Update also see slides

- Defining Urban Indian Populations:
 Urban Indians are an important population to reach as they can experience higher levels of disparities, and present particular challenges in how to identify and reach them. Another challenge is that access to IHS services is eliminated when, due to intermarriage, they no longer have the required blood quantum for membership to any federally-recognized tribe.
- STD/HIV Performance Measures Initiative:
- Government Performance & Results Act (GPRA) measures
- Prenatal HIV Screening - the rate at which pregnant women are being tested for HIV
- HIV Universal Screening - the rate at which a patient aged 13-64 is routinely screened for HIV at least once, regardless of risk factors
- Clinical reporting System (CRS) developmental measures

- STD Screening - the rate at which a patient diagnosed with gonorrhea, Chlamydia, HIV, or syphilis is tested for the other 3 STDs within a period of 60 days)
- Chlamydia screening - the rate at which all women aged under age 25 are screened *annually* for Chlamydia

This could be a great opportunity to reach out to I/T/U facilities in your area to offer to work with them in improving their CRS STD/Chlamydia screening rates. If you are interested in working with facilities in your area, let Scott or Lori know that they can connect you with the appropriate staff and provide the report.

- Additional IHS/National STD Program resources:
 - "Guidelines for STD Screening In Tribal Jails" - JSI has 2 print copies available; otherwise, please contact Lori de Ravello for a copy
 - "Starting A School-Based Chlamydia Screening Project In Indian Country" - downloadable from Project Red Talon's website: http://www.npaihb.org/images/epicenter_docs/aids/2008/Chlamydia_School_Guidelines.pdf
 - *IHS Primary Care Provider* special issue—April 2010, contains information about the "Indian Country: Get Yourself Talking/Get Yourself Tested" campaign - available at <http://www.ihs.gov/provider/>
- Aberdeen Area has the highest Ct/GC rates of any of the reservations in the US.
- "GYT in Indian Country" - Placed a banner ad for an AI/AN-specific widget for entering your zip code to get the closest STD testing centers (all tribal and non-tribal centers) - received 80,000 hits! It was really inexpensive and effective. The widget is available on the CDC/NPIN website at <http://www.cdcnpin.org/stdawareness/tools.htm>
- Tribal colleges do not have clinics on site, which makes it more difficult to reach out to them.
- Native American Calling show on NPR - Lori created a program on AI/AN STDs, but she is unable to carry it forward, as an IHS staff. It needs another person to take the lead and make it happen - talk to Lori de Ravello (lori.deravello@ihs.gov) if you're interested in spearheading it.
- The pilot of the Native STAND peer educator curriculum is complete. It is now in final revision and will soon be available on the web, for anyone to use. Planned Parenthood of MN, ND, and SD got approval to implement a variation of this program.

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| 10:15 am - 11:30 am | <p>Putting American Indian/Alaska Native Health Disparities on the Map <i>Cara James, The Henry J. Kaiser Family Foundation</i></p> | <p>This session will provide an overview of racial and ethnic disparities in women's health, with a primary focus on AI/AN women and the Region VIII states (Colorado, Montana, North Dakota, South Dakota, Wyoming and Utah), specifically focusing on the following areas from the Putting Women's Health Care Disparities on the Map report:</p> <ul style="list-style-type: none"> ➤ Health Status Dimension Scores for AI/AN and for each Region VIII state ➤ Access and Utilization Dimension Scores ➤ No Health Insurance Coverage ➤ No Personal Doctor/Health Care Provider ➤ No Routine Checkup in Past Two Years ➤ No Doctor Visit in Past Year Due to Cost ➤ No Pap Test in Past Three Years ➤ Poverty ➤ Median Household Income <p>The session will then close with an overall discussion, with an overview of the AI/AN Health Care Improvement Act.</p> | <p>Handouts:</p> <ul style="list-style-type: none"> • <i>New Hopes on Health Care for American Indians</i>. by Pam Belluck, The New York Times , December 2, 2009 • <i>Financing American Indian Health Care: Impacts and Options for Improving Access and Quality</i>. Findings Brief - The Robert Wood Johnson Foundation, October 2009 • <i>Legislative Update: Health Care Reform</i>. March 2010 <p>Resources/Display materials:</p> <ul style="list-style-type: none"> • <i>Putting Women's Health Care Disparities On The Map: Examining Racial and Ethnic Disparities at the State Level</i>. The Henry J. Kaiser Family Foundation, June 2009 • <i>A Profile of American Indians and Alaska Natives and their Health Coverage</i>. The Henry J. Kaiser Family Foundation, September 2009, http://kff.org/minorityhealth/upload/7977.pdf |
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Notes:

For the complete presentation also see slides

- Permanent reauthorization of the Indian Health Care Improvement Act is part of the overall health care reform legislation.
- Social determinant of health: employment, but it's not just whether you're employed. It also includes the amount of flexibility your employer allows you to go to take time off to see a doctor, or take your child or other dependent to see a doctor, etc.
- There are many provisions in the bill that will benefit women, and women of color including AI/AN women in particular.
- The health care reform legislation addresses the issue of data gaps/limitations: the bill specifically talks to data collection, including recommendations for collecting data - if you receive federal funds you must collect/report data, and at an amount that has meaning, but still only "to the amount practical."
- Although the bill allows for health care provider loan repayment provisions, the pipeline for when these providers will actually be on the front line providing services is still rather long, so what do we do in the meantime?
- Steven asked whether the data she used can be broken down by county/area within states? Yes, some of it.
- Anticipated effect of HCR on what's going on in MA with regard to Medicaid? States have flexibility, and MA will be able to continue with their plans.
- Of the 17M people who will remain uninsured, 11-12M will be undocumented immigrants; the rest will be those who choose not to get coverage (the penalty is really small, and can only be collected when you file a tax return, which low-income people don't do).

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| 11:45 am - 1:00 pm | WORKING LUNCH <i>State partners meet together</i> | This is a time for state partners to meet and have the opportunity to discuss a few of the strategic plan/workgroup activities: <ol style="list-style-type: none">1. Review of the AI/AN profiles in order to finalize2. Data codebook development3. Private lab participation You will have 90 minutes. Each state will grab lunch and take the first ½ hour to enjoy your lunch then transition into your discussion. | |
| 1:00 pm - 1:45 pm | State Updates II: Review of AI/AN State Profiles and Updates to Related Activities <i>Montana, South Dakota, Wyoming</i> Work Group Strategic Plan Report Backs | One of the benefits of regional meetings is to hear about the great work that other states are doing. During this session, each state will report back the progress, successes, and challenges that they have faced in being able to move forward with their action steps with the plan that was developed during the state/small group discussions begun at the Nov 09 meeting. This is an opportunity for Committee members to hear about work group efforts to address Strategic Plan goals in order for them to provide feedback, raise issues, and/or offer other types of support. | |

Notes:

State Updates:

Montana - At the fall meeting, Montana IPP partners indicated they were planning a site visit trip, sometime in 2010, to 5 tribes/6 reservations over the course of a week. The site visit would include expertise/information on Hep B, epi (Melanie), FP services (Liz), Fort Peck syringe exchange program (Kris)

▪ Status of AI/AN Collaboration:

- They can work with IHS representative again now that a new HIV/STD representative is in place.
- SAMHSA has a grant opportunity for tribal colleges; they are working with them to apply.
- They work with the AETC around HIV and STDs, including trainings around the state.
- Regional workshops - 6 within each segment of the state; PHNs do most of these; they will now include contraception training, in addition to HIV, STDs, and hepatitis; also info on interviewing and reporting; workshops will be conducted over one week in September.

South Dakota - At the fall meeting, South Dakota IPP partners shared information about the successful intervention/collaboration, the Tribal school-based screening program (Terry Friend's program) in SD, and indicated that they would start sharing the information and materials that Stephanie and others provided with tribal resources.

• Status of AI/AN Collaboration:

- They are implementing the MAVEN system. Still can't get reports out of MAVEN, but hopefully soon.
- They have updated their partner services activities.
- System initiates investigations on the priority populations; clinics are given instructions on how to report cases. The number of reports coming in from clinics has increased, as well as requests for medication assistance, EPT.
- Terry Friend is still doing the tribal school-based screening program. The state STD program's only involvement is follow-up on positives, which tribal health believes is a state health department responsibility (good or bad). STD is not on the list of priorities for the tribal health board, and they don't expect this to change.

Wyoming - At the fall meeting, Wyoming IPP partners indicated that they have already identified several partners, for example the new WHC board member is the tribal liaison for the governor's office for the Arapaho Nation/Wind River Reservation and have good partners/contacts with the communicable disease nursing liaisons for both Arapahoe and Fort Washakie IHS. The next step is to bring all together to begin discussions and data sharing.

• Status of AI/AN Collaboration:

- Wind River Reservation - Fremont County Nursing Office has increased their urine-based testing services. This was done as a result of feedback received from Native American teens who expressed that they don't want to utilize the IHS facility, and they had nowhere else to go.
- National Park Service-Yellowstone Project
 - Approx. 3,000 employees annually - summer
 - Approx. 1,500 are women in their target population (<26 years)
 - Starting May 15, will do testing at 5 locations where the dorms are located - urines for men, self-collected vaginal swabs for women (i.e., if their clinical protocol is approved; otherwise, they'll collect urines from women too)
 - Marketing campaign will include putting up posters in all dorms
 - IRB is being done through the WY Department of Health; they have received preliminary consent, and final consent is expected by May 31
 - Will have 2-3 testing staff at each location, in 2 shifts from 6:00am to 10:00pm
 - Received \$5 iTunes gift cards to use as incentives
 - Will also provide condoms
 - Kick-off event is planned for June 28-30
 - They will also be conducting partner services
 - Medcorps staff will provide treatment for positives

Work Group Reports:

▪ Clinical Services Work Group

- Time to Treatment Performance Measure Worksheet
 - Worksheet #1A: CT Testing in JV Facilities

- In SD, the interest among juvenile detention centers is variable. Sioux Falls is interested. Local DIS feels it is important so they will go out once a week to provide an informational session and STD testing. However, this doesn't capture the juveniles who are admitted and discharged on the same day. Regarding screening in the Native population, if the tribe supports the testing the state will go along with it, but without support from the tribe the state backs off.

- Utah's goal (to be added to the PM worksheet) is to increase where they are currently. Emily suggested that 50% might be ideal, but questioned whether this is realistic.
- South Dakota's goal (to be added to the PM worksheet) is to test as much as resources will allow.
- Correction to Colorado's # of facilities: 8 out of 14.
- Utah's screening coverage is 116 out of 563.
- Worksheet #1B: Positivity in JV Facilities
 - In South Dakota, there is not true screening rate because the data is on kids who have been tested in the past three months, providing a snapshot, but what does it really mean? It's also hard to know because the numbers are so low.
 - Utah's estimated positivity for all sites is 12 out of 116. The rate is low due to limited resources and the fact that the nurse is only there twice a week and may miss kids who are in/out in the same day.
- Worksheet #2A: Timely Treatment of Women with CT at FP Sites
 - All of Utah's FP sites are Planned Parenthood sites.
 - In Wyoming, they have additional public health nurse sites that receive Title X funding, but those are not included.
 - At the CDC, the definition is all prevalence monitoring family planning sites and in some states it is even more limited to those tests that are funded by IPP.
 - Wyoming's data currently in the spreadsheet will need to be adjusted when the IPP data gets corrected. Canyon Hardesty and Yvonne Hamby have already discussed the data and the process of correcting how things are coded is currently under way. The denominator for Wyoming has been decreasing since 2006. From January 2008 on, JSI has been including this data.
 - Colorado's estimated timely treatment will need to be corrected in the worksheet, as Kelly discovered that those without a record of treatment were not included.
 - South Dakota has 10 full-service Family Planning sites.
- Worksheet #2B: Timely Treatment of Women with GC at FP Sites
 - Kelly asked the question of, for GC, how are people thinking about working in high morbidity areas? In Colorado, there has been a 30-40% drop in GC cases in recent years, which is raising a red flag. CDC did comment that GC rates decreased across the U.S. from 2008 to 2009.
- Worksheet #3A: Timely Treatment of Women with CT at STD Sites
 - In Colorado, the treatment information was put into the "notes" section within the PRISM database so they need to figure out how to pull out the data since it is not being entered into the correct field. Steven Shapiro suggested that Colorado speak with Florida, as they are also using PRISM. The GC numbers are so small in Colorado they are probably spending more time trying to pull data out of the system than just running a line report and manually calculating the performance measure.
- Worksheet #3A: Timely Treatment of Women with CT at STD Sites
 - The GC numbers are so small in Colorado they are probably spending more time trying to pull data out of the system than just running a line report and manually calculating the performance measure.
 - CDC added that state data takes precedence over regional screening guidelines when using data to inform practice, which is why there has been no discussion about regional screening guidelines in recent years. States have a lot more data available to them than just the data provided by JSI (IPP Infrastructure) and CDC, so states are encouraged to refer to any/all data sources that might be helpful.
- General Comments and Overall Points for Presentation to the RAC
 - The point of this activity is to think about how data is collected, reiterate the challenges of developing a regional standard, and think more process oriented than merely looking at the numbers. For example, to consider what each state is counting as an IPP case? Why are certain FP sites included but not others?
 - A change in database and/or staffing may impact the denominator or numerator, as well as the overall integrity of the data. This is highlighted by significant variability in these data points over the last few years. This may be attributable to how a performance measure was manually calculated in the past or how one database pulls the data compared to another.
 - The discussion on performance measures is ongoing. When the work group members feel that the specific data in the worksheet is complete, they will share the information with the RAC members. Next steps will be to identify how processes differ across the region and how states count IPP and FP sites.
- **Data Work Group -**
 - **Review data dictionary template and prepare for discussion at state meeting**
 - Goes to state lab to fill in the yellow highlighted parts.
 - Establish consistency
 - Section II

- Program fills in any deviation from Regional Screening Criteria
- Section IV
 - Lab fills in test type
- Section V-Core Data Elements
 - Lab IT must complete the field name, type, length, and coding
 - Regional values - If lab codes differently, then they must write their definition in last column so JSI can map state definitions to regional definitions
- Section VI/Enhanced Data Elements
 - Same model as above
 - Change on reason for visit - used to be composite variable, but now each selection has its own row
- Section VIII
 - Completing checklist would decrease time lag in completing data
 - Send quarterly
- Section IX
 - Confirm file format
 - Yvonne/JSI will check in with labs re where they are in transitioning
 - Time frame for completion of the data dictionary template is mid June (6/15)
- **Review data management/system overview**
Yvonne/JSI provided a picture of how time- and labor-intensive the data management process is. Discussion included concept of using the porn industry to model good public health behaviors!
- **Reviewing Screening Criteria Report: 2006-2008** - discussion tabled for future work group conference call
- **Review 2008 screening coverage report**
 - For FP clinics, how many eligible females were screened?
 - Table I - age breakdown of all women
 - Table II - Chlamydia screening
 - By March 1 each year, send these tables
 - By June 4, 2010, send 2005-2009 table to Yvonne/JSI (email yhamby@jsi.com or fax 303-262-4395)
 - Should we set 80% as the minimum coverage before we apply the 3% positivity to shift funds?
 - Yvonne would look at database of females ≥ 25 screened for appropriate reason
 - Test utilization table - not unduplicated females, but number of tests
- **Laboratory Work Group -**
 - **Impact of private lab participation on regional advisory committee**
Discussion: Private labs just providing testing services isn't an issue. The work group agrees with the NCLC policy. It is difficult for foresee, and would be awkward and block progress, if for-profit labs were involved in policy or programmatic decisions. Also, if you invite one for-profit lab to attend a meeting, we would have to invite all. This includes corporate labs as well as small private labs such as those at hospitals. For-profit labs have different priorities than do public health labs.
 - **Lab costs**
Discussion tabled to next work group conference call. Laura will send to JSI the latest version of the cost spreadsheet, including the information she received from WY and UT. JSI will send this version to the work group members and schedule the next call.
 - **Competitive services that can be provided by public health labs**
Public health labs can gain an advantage over for-profit labs by providing the following services:
 - Electronic reporting
 - Faster turnaround
 - Significantly lower pricing
 - Medicaid billing
 - this would stretch the IPP dollars
 - there are challenges, including having to hire additional staff
 - will bring in a lot more Ct/GC testing, but this will also increase the issue of more Ct tests for which the GC result would need to be turned off
 - Data is directly reported to appropriate disease control agencies [this is already being done]

- “A public health lab is supposed to do what the commercial labs won’t do.” -work group member
- Update: Claudia (WY-Lab) talked to Kevin, accounting rep from GenProbe, about test price. CO WY UT all pay the same price—why do other 3 states pay more? Claudia will send Kevin an email about this, who will shuffle it up the GP chain to find out why and how it can be fixed. Volume pricing should be standard across all states within each HHS region.
- In CO, because more than half of their FP clients will likely become Medicaid patients, they must start billing Medicaid. Therefore, if the state lab is to continue to process CT tests, it must also be able to bill Medicaid.
- Also must be aware of latest technologies.
- **Executive Committee Report:**

Due to travel restrictions, time, etc., the Executive Committee suggested the following changes to the RAC meetings:

 - Face-to-face RAC meetings will be conducted one time per year, 2.5 to 3 days
 - JSI will conduct site visits/state meetings at each state each year. This would also increase participation of all 3 state partners. Would also allow inviting other appropriate HD staff to participate. And could be tailored to the needs of each state. Site visits in the upcoming fiscal year (2010-2011) will be on site; subsequent year site visits may be conducted either on site or by video/web conference.
 - JSI will also conduct other ad hoc sessions by videoconference or webinar as the need arises.
 - Work group calls will be conducted quarterly instead of monthly.
 - We will try this over the next 2 years to see how it works.

General resources/display materials:

- *Office of State, Tribal, Local and Territorial Support (OSTLTS; pronounced “stilts”),* a new office of the Centers for Disease Control and Prevention - website: <http://www.cdc.gov/ostlts/>
- *Indian Health Surveillance Report - Sexually Transmitted Diseases 2007.* Indian Health Service National Sexually Transmitted Disease Program, http://www.cdc.gov/STD/stats/IHS/IHS-SurvRpt_Web508Nov2009.pdf