

## **REGIONAL INFERTILITY PREVENTION PROJECTS**

### ***JSI RESEARCH AND TRAINING INSTITUTE PROPOSAL REGION VIII***

- **Describe major accomplishments/successes, obstacles, and significant issues affecting the project for this budget period. Include any significant events expected to occur the last quarter (04/2006-06/2006) of the budget period.**

#### **A. Project Summary for Budget Period : July 1, 2005 – June 30, 2006:**

##### **❖ REGIONAL PLAN**

At the November 2005 meeting, the Committee revised its regional strategic plan (Appendix A). The Executive Committee identified three priority areas, and the Regional Advisory Committee (RAC) developed goals related to these priority areas. The November 2005 meeting focused on these three priority areas: Effective Use of Resources, Partner Services/Treatment Verification, and Laboratory Services. Technical experts gave presentations focusing on each priority area to the entire committee and then assisted workgroups in creating goals, timeframed objectives and activities.

Committee members were assigned to workgroups based on their levels of interest and area of expertise. The Executive Committee also ensured that workgroup members were geographically diverse and representative of all three project areas. JSI staff participates in workgroup conference calls and provides logistic support when needed. Workplans are included in Appendix A.

Following is a summary of workgroup accomplishments.

Effective Use of Resources Workgroup - Prioritizing ways in which data can be effectively utilized are at the forefront of the Project's agenda. Data activities continued as the Committee pursued the priority area "Effective Use of Resources" as part of the regional plan. During this budget period, the group met its first objective, which was to provide web-based user-friendly data reports. State partners can be customize reports and then download them into a Word document.

Another significant data activity involves reviewing the quality of the data to ensure that appropriate data is being collected in a timely manner. The Effective Use of Resources workgroup is continuing to work on ensuring uniformity of definitions of data fields and providing issue-specific reports to committee members.

Other future activities for the workgroup include:

- Identifying trends in the number of chlamydia screenings performed over time according to age, gender, and population/agency (e.g. family planning, community health center).
- Assessing current data to determine which variables/elements are useful to the Region for making decisions (streamlining will allow for better data collection and will result in more complete datasets).

- Producing various regional analyses of:
  - Male positivity,
  - Adherence to screening criteria, and
  - Re-infection rates

Partner Services/Treatment Verification - The workgroup has informally surveyed agencies in their respective states regarding Expedited Partner Therapy (EPT) practices. The group has also collected regulations and rules around EPT practices. These activities will be assembled into a resource guide to be available to agencies considering using EPT as one of their strategies used to manage partners. This guide will be a Region VIII-specific supplement to the work currently being done at the national level.

This workgroup has also agreed to review the Performance Measures Data once it has been collected and released by CDC in order to determine whether Region VIII should develop its own set of standards.

Laboratory Services – The Lab workgroup has been working on establishing a regional lab for alternate source NAAT testing for Chlamydia and Gonorrhea. Working closely with the National Laboratory Consultant and John Papp at CDC, the committee is reviewing the protocols for assay verification. The workgroup is also focusing its efforts on reducing testing costs through negotiating lower regional prices with GenProbe and potentially pooling NAAT specimens.

The Regional Advisory Committee held their spring meeting in April 2006. The cornerstones of this meeting were:

- Teambuilding, focused on continuing to improve the goal implementation process
- Data Training, discussed above and focused on providing committee members with the tools needed to analyze their own IPP data
- Communicating Test Results, focused on how test results are communicated with patients by providers on the frontlines of STD prevention
- Lab Technology Update, focused on validation protocols for alternate test sites

#### ❖ **Obstacles --7/1/2005 to 6/30/2006**

Travel restrictions continue to be an obstacle for certain states that are attempting to send committee members to the IPP RAC meetings.

- **Describe the number of regional committee members by type of organizations represented – using a table format. Please indicate the number of committee members who are traveled with infrastructure funding.**

#### **Membership**

Three membership distributions exist within the Region VIII Chlamydia Project: 1) Regional Advisory Committee (RAC) Members, 2) Ex-Officio Members and 3) Affiliated Public and Private Health Representatives. See Appendix B for a complete and current list.

(1) The Regional Advisory Committee consists of representatives from each of the following programs: Title X-funded family planning program, state department of health STD program, state public health laboratory, for a total of three representatives from each state. Table 1 describes the number of regional committee members by type of organization represented.

On occasion, RAC Members may be unable to attend meetings or participate on conference calls and they may designate others from their programs to serve in their capacity. When this regional project was established in July 1992, representatives from the Denver City County Health Department (DPH) were present and requested membership to the RAC. Their involvement and participation has been limited; however in this and past project years, representatives from the Region VIII STD Prevention Training Center (housed at DPH), have attended the RAC meetings and/or given presentations. Staff from the DPH STD Clinic have also attended and presented on special chlamydia related projects as well.

(2) Ex-Officio Members consist of JSI staff, representatives from CDC, the Regional Office for Family Planning and the National Laboratory Chlamydia Coordinator.

(3) Affiliated Public and Private Health Representatives include those who have requested to receive project information: directors of public health programs such as laboratories, family planning and STD; Indian Health Services (I.H.S.), and CDC. These representatives have recently included two collaborative partners in college health services.

Table 1. Regional committee members by type of organization represented Fiscal Year 2005-06.

	<b>Colorado</b>	<b>Montana</b>	<b>North Dakota</b>	<b>South Dakota</b>	<b>Utah</b>	<b>Wyoming</b>
Family Planning	Christine Mandl	Ellie Hardy	Becky Bailey	Bev Duffel	Penny Davies	Carol Peterson
STD	George Ware	Lisa Underwood	Kim Weis	Dave Morgan	Tim Lane	Sharon Renter
Lab	Jim Beebe	Susie Zanto	Michael Trythall	Yvette Thomas	Tom Sharpton	Claudia Rogers

**Number Paid for in Infrastructure Budget**

With meetings being traditionally held in Denver, travel funds to attend meetings are available to RAC members from five of the six states. Colorado representatives receive support as indicated, such as parking fees at meeting location and mileage to and from the meetings. When participation of other individuals is determined to be important to the project and support is indicated, JSI works with the RAC Executive Committee to make travel support available. Depending on meeting attendance, support has been made available to a minimum of 15 participants to a maximum of 20. For the October 2005 meeting, travel support was made available to one expert presenter to address Partner Management, a topic related to the Strategic Plan. For the April 2006 meeting, travel support was provided to a session panelist.

- **If applicable, describe changes that have occurred during this budget period to the regional advisory committee structure, including changes in the number of members and types of organizations represented. Describe how new members were recruited/selected/oriented.**

The Regional Advisory Committee consists of an Executive Committee, a Lab Subcommittee and ad hoc workgroups as required.

In October 2005, the Executive Committee changed hands for the 2005-2007 term. The 2005-2007 committee comprises of:

**Colorado:** Christine Mandl (Family Planning)

**Montana:** Lisa Underwood (STD)

**North Dakota:** Kim Weis (STD)

**South Dakota:** Yvette Thomas (Lab)

**Utah:** Tom Sharpton (Lab)

**Wyoming:** Carol Peterson (Family Planning)

Workgroup membership is described below:

**Lab Services Workgroup Members:** Jim Beebe (CO-Lab), Mike Trythall (ND-Lab), Tom Sharpton (UT-Lab), Claudia Rogers (WY-Lab), Susie Zanto (MT-Lab), Rick Steece (IPP), and John Papp (CDC).

**Effective Use of Resources Workgroup Members:** Christine Mandl (CO-FP), Lisa Underwood (MT-STD), Kim Weis (ND-STD), Yvette Thomas (SD-Lab), Penny Davies (UT-FP), Lydia Blasini-Alcivar (CDC), and Carol Peterson (WY-FP).

**Partner Services/Treatment Verification Workgroup Members:** George Ware (CO-STD), Keese Rietmeijer (DPH), Dave Morgan (SD-STD), Ellie Hardy (MT-FP), Tim Lane (UT-STD), Becky Bailey (ND-FP), and Greg Walsh (WY-STD).

The RAC has experienced turnover of several members this project year.

North Dakota: Barb Schweitzer stepped down from her position and selected Becky Bailey to be her replacement on the Committee. Her first attendance was at the April 2006 meeting. Kirby Kruger also appointed Kim Weis as his replacement on the committee. Eric Heib was replaced by Michael Trythall.

Montana: Laurie Kops selected Lisa Underwood as her replacement on the committee.

### **Orientation and Retention Strategies**

New members receive an orientation packet containing information on the background and goals of the Region VIII project, regional plan, project protocols, and training resources. The entire content of the notebook is also available electronically via the Project's website at <http://www.region8ipp.com/orientation.shtml>. JSI staff conducts a welcome and orientation phone

call to new members to answer questions and address concerns. JSI staff also provides support requested by state partners in orienting their state's new member.

- **Describe the number of face-to-face meetings occurred of the full committee and any subcommittees during this budget period. If subcommittees met by teleconference, estimate the number of conference calls for each subcommittee during the budget period. Please include notes from conference calls in an appendix.**

The Region VIII Chlamydia Project schedules two face-to-face meetings each year for members of the RAC. These meetings are planned for one and a half days. One to two conference calls are typically scheduled for each meeting, at which time the Executive Committee gives recommendations for agenda changes and gives final approval. Minutes are produced for each full committee meeting. JSI writes these with review and final approval by the Executive Committee. See Appendix C for November 2005 meeting agenda and minutes and Appendix D for April 2006 meeting agenda and minutes.

The Region VIII Project Meeting structure has differed over the years. In 1994 and 1995 the RAC met four times each year. In 1996 meetings were reduced to three per year and starting in 1997 the RAC decided to meet twice a year. Face-to-face meetings are supplemented significantly with conference calls. The use of email and faxes is significant in this region. The workgroups also meet monthly via conference calls. Please refer to Appendix E for workgroup call notes.

The purpose of the Advisory Committee meetings is to plan the strategies and associated activities for implementing the chlamydia prevention program. They provide opportunities for colleagues to meet and share information related to chlamydia. The meetings also allow for detailed discussion and decision-making in the key areas that make up the prevention program. The procedure by which decisions are made for the project is conducted through an informal process. The process consists of consensus and/or voting. Only the RAC members have decision-making privileges.

JSI is responsible for conference call arrangements, including scheduling times and dates, developing an agenda, distributing notices about and notes after the call. The Infertility Project funds conference calls.

- List each objective for the budget period and describe progress that was made between July 1, 2005 and March 30, 2006. If no or limited progress was made, describe factors that have impeded progress, and a plan to address these factors (if applicable).
- If objectives changed from those described in the previous infrastructure plan, provide an explanation for the change.

**B. Progress Report for July 1, 2005 - March 30, 2006**

**Objectives:**

Measurable, time-phased objectives were proposed for each of the following categories: administration, coordination, communication, data management and analysis, and program promotion. For each objective, methods or activities outlined how the objective was to be accomplished.

**ADMINISTRATION:**

**OBJECTIVE 1:** Prepare and submit infrastructure and regional plans and required reports to CDC by specified due dates, but no later than June 30, 2006.

**METHODS:** a) JSI will respond to the Regional Infertility Prevention Projects Infrastructure Application Guidance and develop a work plan pertinent to the Regional Coordinator Roles and Responsibilities document.

b) JSI will work with the Region VIII RAC to develop a Regional Plan which is responsive to the Infertility Prevention Project Regional Plan Guidance and which will move the Region VIII IPP Project ahead in meeting long-term goals stated in the Coordinator’s Visioning Document and the DSTDP’s Strategic Plan.

c) JSI will prepare and submit any other required reports to CDC and OPA in accordance with the funding Memorandum of Agreement.

**STATUS:** The Project staff developed the Regional Infertility Prevention Project’s infrastructure application in response to the pertinent tasks and activities from the “Regional Coordinator Roles and Responsibilities” document, the Region VIII Regional Plan and the “Creating the Future: A Strategic Plan and Vision for the Regional Infertility Prevention Projects” document. The infrastructure plan was shared with CDC, OPA and the Region VIII Family Planning Regional Office.

The Project Staff worked with the Region VIII Executive Committee to develop and finalize the Regional Plan. The Regional Plan covered three main priority areas that were responsive to the IPP’s Regional Plan Guidance and will help move the Project ahead in meeting long-term goals. See Appendix A for Regional Strategic Plan.

Lastly, JSI has prepared and submitted any other required reports to CDC and OPA such as the bi-annual and year-end data reports, as well as meeting minutes. These were shared with the Program Consultants for each applicable state and the appropriate Public Health Advisor with the Region VIII

Family Planning Regional Office.

**COORDINATION:**

**OBJECTIVE 2:** Promote the goals and objectives of the project by supporting the planning process for two regional meetings via at least two conference calls conducted by June 30, 2006.

**METHODS:** a) Two RAC meetings will be held during the 2005-06 project year. Meetings are currently slated for October 2005 and May 2006 in Denver, CO. Conference calls will be set up for the Executive Committee, Laboratory Subcommittee, and existing workgroups within 10 weeks before the meeting dates to plan the meeting agenda.

b) Arrange for transportation, meeting coordination of information, identification and coordination of consultants for each RAC meeting.

c) Develop draft form documents and distribute the reports within eight weeks after each RAC meeting and within 4 days of conference calls.

**STATUS:** For the 2005-2006 project year there were four Executive Committee meeting conference calls from November 2005 to March 2006, as well as at least three conference calls for each of the workgroups: Lab Services, Partner Management/Treatment Verification, and Effective Use of Resources. Additionally, one RAC meeting was held in April 2006 (Denver, Colorado) and at least two more conference calls per workgroup are scheduled for the project period between April and June 2006.

The October 2005 meeting focused on the three prioritized goals (Laboratory Services, Partner Management/Treatment Verification, and Effective Use of Resources) from the Strategic Plan. The April 2006 meeting continued to center around efforts toward the goals outlined in the Strategic Plan. The total amount of days for both the October 2005 and April 2006 meetings is 3 days, for which the Project staff coordinates all arrangements. See Appendix C for the October meeting agenda and minutes and Appendix D for the April meeting agenda and minutes.

**OBJECTIVE 3:** Increase opportunities for communication and collaboration among CDC, JSI, and project areas between July 1, 2005 and June 30, 2006.

**METHODS:** a) Assess the need for technical assistance or site visits to project areas for the following indications: new participating agency, new RAC representative or if a project area and/or clinic is/are experiencing problems with a specific aspect of the project.

b) By June 30, 2006 complete any identified technical assistance/site visit and create a summary of technical assistance/site visit plan within 2 weeks of completion.

**STATUS:** The Project Director has provided technical assistance to various states to aid in increasing the quality of the data for the project or to aid in receiving data. Specifically, special reports and ad-hoc queries created at the request of several representatives in Region VIII as a means of verifying data sent, to use in a presentation or for the analysis of data pertaining to a special research project. Other special reports were generated for representatives and workgroups to study adherence of screening criteria and male positivity rates by various demographic factors and agency sites. Technical assistance was also provided to workgroups as they implement the Strategic Plan.

**OBJECTIVE 4:** Assist states in implementing at least one prioritized goal from the updated Strategic Plan between July 1, 2005 and June 30, 2006.

**METHODS:** a) Provide logistical support and program guidance to workgroups focusing on at least one goal prioritized in the Strategic Plan reflecting the following priority areas: Effective Use of Resources, Partner Services, Lab Services, and Treatment Verification.

b) Support each state laboratory in obtaining Public Health pricing for tests by gathering information on regional testing volumes and manufacturer volume requirements.

c) Produce data reports and assistance with data analysis to workgroups as needed.

**STATUS:** The Project staff scheduled conference call dates, sent out reminders for conference calls, and participated in conference calls for all workgroup meetings. In addition, Project staff drafted and distributed conference call notes and provided technical support where needed. Project staff worked closely with the National Lab Consultant to obtain regional pricing information for tests. Project staff also produced data reports for analysis and quality improvement where required for progress on workgroup activities.

#### **COMMUNICATION:**

**OBJECTIVE 5:** Participate in 2-3 national meetings and at least nine IPP Coordinators conference calls on behalf of Region VIII between October 1, 2005 and June 30, 2006.

**METHODS:** a) Attend Chlamydia Coordinators meetings two times per year and participate in monthly conference calls

b) Attend other national conferences pertaining to Chlamydia, such as the National STD Prevention Conference every other year.

c) Report pertinent information appropriate to the RAC within 2 weeks of participating in IPP Coordinator conference calls.

**STATUS:** The Project staff attended one Chlamydia Coordinators meeting in November 2005, and staff are also planning to attend the Coordinators meeting scheduled for June 2006. Pertinent information about all meetings and email announcements is relayed to the RAC during

conference calls, meetings, email, and via the project website. Project Staff will attend the National STD Prevention Conference in May 2006. Additionally, Project Staff participated in the monthly coordinators conference calls and gave updates to the RAC via email.

**OBJECTIVE 6:** Communicate national and local research activities and results to project partners between October 1, 2005 and June 30, 2006.

**METHODS:** a) Utilize the Region VIII Chlamydia Project website with the primary purpose of acting as a central repository for disseminating ongoing information about the project to its stakeholders as well as the general public.

b) Continue to provide timely and relevant resources and updates via email, US postal mail, phone, and in person at regional meetings.

**STATUS:** The Project's website, [www.region8ipp.com](http://www.region8ipp.com) contains information about projects, research activities, and events revolving around infertility prevention in Region VIII and across the country. Whenever the site's content is significantly updated, an email memorandum is sent to the Advisory Committee. Information is also continuously shared via email, US postal mail, and in person at regional meetings.

#### **PREVALENCE MONITORING DATA MANAGEMENT AND ANALYSIS:**

**OBJECTIVE 7:** Submit four complete, accurate and timely prevalence monitoring data files to CDC by June 30, 2006.

**METHODS:** a) Work with the Regional Advisory Committee to facilitate monthly delivery of data.

b) Receive, review and document receipt of monthly data files and forms. Automatically generated email reminders are sent to project areas on the first of each month indicating that data is due in fifteen days. If necessary, follow-up calls are made to project areas to encourage timely submission of data. Project staff will consult with other regional coordinators to assess best practices.

c) Monitor data quality and consistency as new data are added to the database.

d) Provide CDC with clean data collected at quarterly intervals. Provide CDC with an updated, comprehensive data file containing all valid data collected during a one-year interval.

**STATUS:** The Project Director processed data for six states, which includes six State Health Labs and five City or County Health Labs in Region VIII, which were used for state and regional reports. The Project Director combined a year's worth of data from all six states and transmitted them to CDC. The Project Director worked closely with CDC on this task in order to ensure successful transmission. Additionally, the Project Director provided data files to I.H.S.

**OBJECTIVE 8:** Provide data management to the six primary project areas (the state laboratories), and the four city and county labs in Colorado that provide data directly to the regional database and requested technical assistance to at least five project areas by June 30, 2006.

**METHODS:**

- a) Work with each state on an individual basis to research and report back any discrepancies in the data format or coding structure.
- b) Communicate data dictionary requirements and resolve issues related to data quality.
- c) Perform analyses on the data to verify data quality or identify potential problems.

**STATUS:** The Project Director has provided technical assistance to various states to aid in increasing the quality of the data for the project or to aid in receiving data. Special reports and ad-hoc queries were created at the request of several representatives in Region VIII as a means of verifying data sent. Data analysis was provided as a follow-up analysis of data pertaining to the Male Morbidity Workgroup. The results of this data analysis were presented at a poster session at the 2006 National STD conference. Finally, data analyses were also provided for the Effective Use of Resources Workgroup; these results were presented to the RAC at the April 2006 IPP meeting.

In terms of performing analyses on the regional data to verify data quality, the Project Director initiated an assessment with each state/lab which compared the number of records sent to regional database, number of records remaining in the database and number of records discarded due to missing one of the 4 variables required to be entered into the database: DOB/age; name/soundex; collection date; and test result.

**OBJECTIVE 9:** Provide data entry for four project areas that do not have staff to support keying activities between October 1, 2005 and June 30, 2006.

**METHODS:**

- a) Receive, review and document monthly receipt of lab slips and forms.
- b) Perform data entry of designated data elements and review quality.
- c) Organize and securely store lab slips so as to maintain confidentiality.

**STATUS:** JSI provided data entry for the states/labs (Colorado small labs and South Dakota) for a total of approximately 10,000 records for July 1, 2005 through March 31, 2006. The electronic file and lab slips are logged into the data receipt log on the date they are received, the date the electronic file is imported into the database is logged as well as date the lab forms are completed for keying is logged. Lab forms are kept in secure filing cabinets for a period of one year then transferred to an off-site storage facility where they are kept for an additional year then they are destroyed.

**OBJECTIVE 10:** Oversee and facilitate requested analyses of regional prevalence monitoring data in order to inform program planning and evaluation efforts between July 1, 2005 and June 30, 2006.

**METHODS:** a) By April 30, 2006, develop web-based tutorial for accessing and interpreting data reports.

b) By April 30, 2006, produce at least one regional analysis such as comparison of positivity rates of males; re-infection rates; or screening criteria adherence.

**STATUS:** The Effective Use of Resources workgroup is continuing with its activities including a series of data training sessions. The first session was conducted at the April 2006 RAC meeting. The focus of this session was to provide RAC members with the tools to use the web-based reporting system to identify screening trends and produce various regional analyses such as screening criteria adherence and re-infection rates. Overall, RAC members gained the tools to assess the data to determine which variables/elements are useful for decision-making. The group is also now able to produce user-friendly reports.

Data analysis was provided as a follow-up analysis of data pertaining to the Male Morbidity Workgroup. The results of this data analysis were presented at a poster session at the 2006 National STD conference. Finally, data analyses were also provided for the Data Use and Effective Use of Resources Workgroup; these results were presented to the RAC at the April 2006 IPP meeting.

**OBJECTIVE 11:** Disseminate data within the region between July 1, 2005 and June 30, 2006.

**METHODS:** a) By June 30, 2006, produce user-friendly data reports that are accurate, timely and easily transmittable into other applications. All datasets spanning from 1994 to the current data posting will be available for programs to access for reporting.

**STATUS:** In the past, data reports have not been provided in a timely manner due to the delay in the roll-out of the web-based reporting system. The issues related to this delay have been resolved, and the new web-based reporting system was rolled out at the April 2006 meeting. A data training accompanied this roll-out, and RAC members had the opportunity to try out the new system during the meeting.

### **Data Collection:**

**Describe:**

- **How data were collected and transferred from the local to state to regional infrastructure and then to CDC. If the process varied substantially by project area, include a description of each state/project area. Include regional timelines by which data were submitted from the project areas to the infrastructure and any obstacles or barriers associated with data collection, transfer, and submission. Describe what steps were taken to address obstacles or barriers.**
- **The number of clinics submitting data to the IPP by site type in each project area, number of chlamydia and gonorrhea tests by site type by gender in each project area, and types of laboratory tests used in the region by project area. If the number of clinics submitting data in 2005 changed from the previous year, please indicate the change in parentheses, e.g., 22 (-3) would indicate that 22 clinics submitted data in 2004 and this was a decline of three clinics from the previous year.**

Demographic, clinical findings, and behavioral risk data collected during the medical visit are recorded on a lab slip or data collection form that accompanies the test specimen to the medical lab. At many sites, lab test results and lab slip information are captured by means of data entry in the laboratory. Data and/or the lab slip are then transferred to the infrastructure at JSI on a monthly basis. Data are transferred electronically by attaching the data file and sending it via e-mail.

Montana, North Dakota, Wyoming and five labs in Colorado capture all of the required data elements and send complete data to JSI. These files are due on the 15th of each month. No project area met the data deadline 100% of the time. Following are the respective deadlines for each project area: 75%, 50%, 66%, 75%, 0% (four labs), 58% and 50% of the time.

South Dakota lab captures a subset of the required data elements. The lab transfers their data and a copy of the lab slip to JSI where data on the remaining elements is keyed. These files are due on the 10th of each month. South Dakota met the data deadline 50% of the time.

JSI provides all data entry for one Colorado lab and for two Family Planning, Title X Clinics. This lab and two clinics transfers a copy of the lab slip to JSI, where all data elements are keyed. The lab slips are due on the 10th of each month. This project area met the data deadline 31% of the time.

Denver General Health (Lab7) modified data elements submission and format changes due to compliance with HIPAA. The medical record number and birth date are no longer transmitted in the files. The new patient id number is an encrypted number so that the patient's identity is not identified. Using this new id number will still allow calculation of various user statistics while remaining under the guidelines of HIPAA. If the same patient has received more than one lab result, the new patient id number will be the same for each occurrence so that multiple tests for the same patient can be tracked.

The following data elements are now submitted:

- Encrypted Patient identifier
- Age
- Gender
- Race/Ethnicity
- Test result
- Collection Date
- Test type
- Specimen Source

Transfer Electronic Data (No data entry done by JSI)

Lab	ID	State	Format	Extension	Transfer	Data Fields
Colorado State Lab	1	CO	FF	.xls	E-mail	all
Denver Public Health	2	CO	FF	.exe	E-mail	all
El Paso County	3*	CO	FF	.out	E-mail	all
Mesa County Lab	6	CO	FF	.xls	E-mail	all
Denver General Hosp	7	CO	CSV	.dat	E-mail	modified fields**
Montana	9	MT	FF	.txt	E-mail	all
Utah	10	UT	FF	.txt	E-mail	all
North Dakota FP	13	ND	FF	.txt	E-mail	all
North Dakota NFP	13	ND	FF	.txt	E-mail	all
Wyoming	12	WY	FF	.txt	E-mail	all

\*This is for all screening and testing outside of FP, Title X

\*\* Modified data elements submission and format changes were due to compliance with HIPPA in the data set so that the medical record number and birth date are no longer transmitted in the files.

Transfer Electronic Data (Partial data entry done by JSI)

Lab	ID	State	Format	Extension	Transfer	Data Fields
South Dakota	11	SD	CSV	.epv	E-mail	demographics/results

Transfer Data Collection Forms and Lab Slips (All data entry done by JSI)

Lab	ID	State	Electronic	Form Type	Transfer
Larimer County	5	CO	None	Collection Form	Mail
Weld County	5	CO	None	Collection Form	Mail
Clinic:					
Teller County FP, Title X	1	CO	None	Collection Form	Mail
El Paso County FP, Title X	3	CO	None	Collection Form	Mail

The Region VIII Chlamydia Project Database is comprised of data collected at 388 different sites across a six-state region. In 2005, 255 agencies received funding to perform chlamydia screening and collect data. These agencies collect demographic data and test results (core data elements) as

well as clinical symptoms, risk and behavioral factors (extended data elements). In addition, 133 agencies that did not receive funding contributed core data elements to the project. A total of thirteen different types of healthcare agency or medical facility conducted Chlamydia screening and/or contributed data to the project.

### Number of Agencies Participating in Screening and Collecting Extended Data

Agency Type:	CO	MT	ND	SD	UT	WY
Adolescent Clinic	1	1(+1)	0	0	0	0
Community-based Org.	7 (+4)	0	0	0	3(+3)	0
Community Health Center	4	4(+4)	0	0	10 (+4)	0
Correctional Facilities	6 (-1)	5(+5)	0	0	4	0
County Health Department	0	1(+1)	0	0	6 (+2)	0
Family Planning Non-Title X	0 (-13)	0	0	0	2	0
Family Planning Title X	31 (-3)	24 (-2)	8 (-1)	12 (+1)	12(-1)	15
Hospital	0	0	0	0	1	0
Indian Health Service	0	10(+10)	0	0	0	0
Other Public Agency	2 (+2)	1(+1)	0	0	9	2
Public Health Outreach	4	0	0	0	0	0
Private Provider	0	5(+5)	0	0	0	0
School-based Clinic	12 (+3)	0	0	0	0	0
STD Clinic	8(+1)	7 (-1)	0	5	19 (-1)	4(+2)
Student Health Center	2(+2)	0	0	0	5	1(-1)
Substance Abuse Clinic	2	1(+1)	0	0	0	0
Women's Clinic	0	3(+3)	0	0	2(+1)	4(+4)
<b>Total</b>	<b>79 (-5)</b>	<b>62 (+28)</b>	<b>8 (-1)</b>	<b>17 (+1)</b>	<b>73(+8)</b>	<b>26 (+5)</b>

### Number of Agencies Participating by Sending Core Data

Agency Type:	CO	MT	ND	SD	UT	WY
Adolescent Clinic	0	0(-1)	0	0	2(+1)	0
Community Health Center	12(-1)	0(-4)	0	0	0	0
Correctional Facilities	0	3	3	0	0	1(-1)
County Health Department	1	0(-1)	0	0	0	0
Family Planning Non-Title X	1(+1)	0	0	0	0	8
Family Planning Title X	0	0	0	0	0	0
Hospital	0	0	0	0	0(-1)	1
Indian Health Service	0	0(-11)	6	9	0	0
Other Public Agency	2	1 (-1)	1	0	0	2(+1)
Private Provider	0	35 (-6)	4 (-1)	0	18(+13)	1
STD Clinic	0	0	0	0	0	0
Student Health Center	2(+2)	3	6(+2)	0	0	0
Women's Clinic	0	0(-2)	1	0	0	0
<b>Total</b>	<b>18 (+2)</b>	<b>42 (-31)</b>	<b>21(+1)</b>	<b>9</b>	<b>20(+13)</b>	<b>13</b>

### Number of Chlamydia Tests by Agency Type and Gender in Each Project Area: Colorado

Agency Type	Gender	Lab 1	Lab 2	Lab 3	Lab 5	Lab 6	Lab 7
Adolescent Clinic	Male	0	40	0	0	0	0
	Female	0	80	0	0	0	0
	Total	0	120	0	0	0	0
Community-Based Organization	Male	0	106	1	0	0	0
	Female	0	108	0	0	0	0
	Total	0	214	1	0	0	0
Community Health Center	Male	0	67	0	0	0	297
	Female	0	81	0	0	0	10317
	Total	0	148	0	0	0	10614
Correctional Facilities	Male	0	169	286	0	0	0
	Female	0	121	182	0	0	0
	Total	0	290	468	0	0	0
FP, Non-Title X	Male	0	0	0	0	0	0
	Female	1	0	0	0	0	0
	Total	1	0	0	0	0	0
FP, Title X	Male	351	0	0	17	375	0
	Female	11188	0	2191	2296	2549	0
	Total	11539	0	2191	2313	2924	0
Other Public Agency	Male	0	0	19	0	0	0
	Female	45	0	26	0	0	0
	Total	45	0	45	0	0	0
Public Health Outreach	Male	0	94	9	0	0	0
	Female	0	142	7	0	0	0
	Total	0	236	16	0	0	0
School-Based Clinic	Male	0	126	0	0	0	0
	Female	0	623	0	0	0	0
	Total	0	749	0	0	0	0
STD Clinic	Male	429	8435	2120	338	0	0
	Female	151	4719	1774	218	0	0
	Total	580	13154	3894	556	0	0
Student Health Center	Male	1	0	0	0	0	0
	Female	156	0	0	0	0	0
	Total	157	0	0	0	0	0
Agency Type	Gender	Lab 1	Lab 2	Lab 3	Lab 5	Lab 6	Lab 7
Substance Abuse Clinic	Male	0	4	3	0	0	0
	Female	0	5	2	0	0	0
	Total	0	9	5	0	0	0
County Health Dept	Male	7	0	0	0	0	0
	Female	3	0	0	0	0	0
	Total	10	0	0	0	0	0
Unknown	Male	1	0	0	0	0	0
	Female	57	5	0	0	0	2
	Total	58	0	0	0	0	2
<b>Total</b>		<b>12390</b>	<b>14925</b>	<b>6620</b>	<b>2869</b>	<b>2924</b>	<b>10616</b>

**Number of Chlamydia Tests by Agency Type and Gender in Each Project Area:  
Remaining Project Areas**

<b>Agency Type</b>	<b>Gender</b>	<b>MT</b>	<b>ND</b>	<b>SD</b>	<b>UT</b>	<b>WY</b>
Adolescent Clinic	Male	3	0	0	0	0
	Female	7	0	0	3	0
	Total	10	0	0	3	0
Community Based Organization	Male	0	0	0	297	0
	Female	0	0	0	136	0
	Total	0	0	0	433	0
Community Health Center	Male	218	0	0	189	0
	Female	1065	0	0	1340	0
	Total	1283	0	0	1529	0
Correctional Facilities	Male	138	786	0	916	0
	Female	255	107	0	369	6
	Total	393	893	0	1285	6
County Health Department	Male	0	0	0	63	0
	Female	41	0	0	76	0
	Total	41	0	0	139	0
FP, Non-Title X	Male	0	0	0	0	31
	Female	0	0	0	437	1287
	Total	0	0	0	437	1318
FP, Title X	Male	1078	468	95	1073	368
	Female	11694	6743	3181	3972	4221
	Total	12772	7211	3276	5045	4589
Hospital	Male	0	0	0	0	19
	Female	0	0	0	17	40
	Total	0	0	0	17	59
Indian Health Service	Male	1348	386	691	0	0
	Female	5109	2535	5607	0	0
	Total	6457	2921	6298	0	0
Other Public Agency	Male	3	9	0	270	55
	Female	13	60	0	757	924
	Total	16	69	0	1027	879
Private Provider	Male	362	330	0	90	0
	Female	2745	1265	0	1694	0
	Total	3107	1595	0	1784	0
STD Clinic	Male	466	0	601	2343	592
	Female	681	0	1094	2005	530
	Total	1147	0	1695	4348	1122
Student Health Center	Male	31	350	0	90	131
	Female	45	1034	0	238	605
	Total	76	1384	0	328	736

<b>Agency Type</b>	<b>Gender</b>	<b>MT</b>	<b>ND</b>	<b>SD</b>	<b>UT</b>	<b>WY</b>
Women's Clinic	Male	0	0	0	2	0
	Female	480	630	0	18	107
	Total	480	630	0	20	107
Substance Abuse Clinic	Male	139	0	0	0	0
	Female	99	0	0	0	0
	Total	238	0	0	0	0
Unknown	Male	0	0	0	38	1
	Female	0	0	0	3	282
	Total	0	0	0	41	283
Total		26020	14703	11269	16436	9199

## Number of Gonorrhea Tests by Agency Type and Gender in Each Project Area: Colorado

Lab 7 does not provide gonorrhea data to the regional database.

Agency Type	Gender	Lab 1	Lab 2	Lab 3	Lab 5	Lab 6
Adolescent Clinic	Male	0	40	0	0	0
	Female	0	77	0	0	0
	Total	0	117	0	0	0
Community Based Organization	Male	0	105	1	0	0
	Female	0	107	0	0	0
	Total	0	212	1	0	0
Community Health Center	Male	0	64	0	0	0
	Female	0	75	0	0	0
	Total	0	139	0	0	0
Correctional Facilities	Male	0	168	284	0	0
	Female	0	120	181	0	0
	Total	0	288	465	0	0
County Health Department	Male	7	0	0	0	0
	Female	3	0	0	0	0
	Total	10	0	0	0	0
FP, Non-Title X	Male	0	0	0	0	0
	Female	1	0	0	0	0
	Total	1	0	0	0	0
FP, Title X	Male	341	0	0	17	375
	Female	11126	0	2184	2295	2549
	Total	11467	0	2184	2312	2924
Other Public Agency	Male	0	0	19	0	0
	Female	45	0	26	0	0
	Total	45	0	45	0	0
Public Health Outreach	Male	0	92	9	0	0
	Female	0	138	7	0	0
	Total	0	230	16	0	0
School-based Clinic	Male	0	124	0	0	0
	Female	0	616	0	0	0
	Total	0	740	0	0	0
STD Clinic	Male	429	8435	2105	338	0
	Female	151	4719	1750	218	0
	Total	580	13154	3855	556	0
Student Health Center	Male	1	0	0	0	0
	Female	156	0	0	0	0
	Total	157	0	0	0	0
Substance Abuse Clinic	Male	0	4	3	0	0
	Female	0	5	2	0	0
	Total	0	9	5	0	0
Women's Clinic	Male	0	0	0	0	0
	Female	0	0	0	0	0
	Total	0	0	0	0	0

<b>Agency Type</b>	<b>Gender</b>	<b>Lab 1</b>	<b>Lab 2</b>	<b>Lab 3</b>	<b>Lab 5</b>	<b>Lab 6</b>
Unknown	Male	1	0	0	0	0
	Female	57	5	0	0	0
	Total	58	5	0	0	0
Total		12318	14894	6571	2868	2924

**Number of Gonorrhea Tests by Agency Type and Gender in Each Project Area:  
Remaining Project Areas**

SD and ND do not provide gonorrhea data to the regional database.

<b>Agency Type</b>	<b>Gender</b>	<b>MT</b>	<b>UT</b>	<b>WY</b>
Adolescent Clinic	Male	1	0	0
	Female	3	3	0
	Total	4	3	0
Community Based Organization	Male	0	153	0
	Female	0	68	0
	Total	0	221	0
Community Health Center	Male	181	189	0
	Female	996	1294	0
	Total	1177	1483	0
Correctional Facilities	Male	45	245	0
	Female	172	295	6
	Total	217	540	0
County Health Department	Male	0	63	0
	Female	6	76	0
	Total	0	139	0
FP, Non-Title X	Male	0	0	31
	Female	0	437	1287
	Total	0	437	1318
FP, Title X	Male	466	551	368
	Female	2497	1258	4225
	Total	2963	1809	5493
Hospital	Male	0	0	19
	Female	0	5	40
	Total	0	5	59
Indian Health Service	Male	781	0	0
	Female	3458	0	0
	Total	4239	0	0
Other Public Agency	Male	3	96	55
	Female	13	348	924
	Total	16	444	979
Private Provider	Male	308	89	0
	Female	2487	1442	0
	Total	2795	1531	0
STD Clinic	Male	432	857	592
	Female	631	1055	530
	Total	1063	1912	1122
Student Health Center	Male	12	88	131
	Female	17	159	605
	Total	29	247	736
Substance Abuse Clinic	Male	2	0	0
	Female	1	0	0
	Total	3	0	0
Women's Clinic	Male	0	0	0
	Female	24	0	107
	Total	24	0	107

Agency Type	Gender	MT	UT	WY
Unknown	Male	0	30	1
	Female	0	3	283
	Total	0	33	284
Total		12536	8814	9204

### ***Obstacles and Barriers -- 7/1/2005 to 6/30/2006***

In general, data collection and transfer are managed through a standardized process with policies and procedures established by the experienced members of the Regional Advisory Committee with the assistance of JSI staff. The following obstacles and barriers currently exist within the region:

- Delays in receiving data from providers:

JSI staff track and monitor the progress of timely data submission. No project area met the data deadline (15<sup>th</sup> of each month) 100% of the time. Colorado met deadlines 53% of the time; Montana, North Dakota, and Wyoming met deadlines 0% of the time. Utah also met deadlines 58% of the time, and South Dakota, 50% of the time. Automatically generated email reminders are sent to project areas on the first of each month indicating that data is due in fifteen days. If necessary, follow-up calls are made to project areas to encourage timely submission of data.

- Changes in technology and software
- Changes to file format, coding, media used to transfer.
- Changes in agency information:

JSI is not always notified when changes are made to data files such as changes in technology or when agencies have been added, dropped, or the identification codes changed. While quality control processes identify a problem, research and correction of individual records are required to make overall corrections. This can be a lengthy process. Advance notice of changes would eliminate inefficiencies in processing time. JSI continues to remind and request project areas to notify us of changes with data transmission.

### **Data Reports:**

#### **Describe:**

- **The type, frequency, and purpose of reports generated by the project; include how reports were distributed to project areas and other partners including committee members and individual clinics.**
- **How data were used by local clinics, project areas, and the region for programmatic, surveillance, screening criteria evaluation, or other purposes.**

Through the Effective Use of Resources Workgroup, JSI has gathered information on how states are using the data and sharing data with clinics participating in the project. At the state level the data is

used to write grants, and two states use the data as a tool to monitor clinical practice. Following is an example of how one state uses the data from the project: The Title X RAC representative sends positivity reports for each Title X clinic submitting data. On the reports, the state rates for teens and for total population are written just under the clinic's rate. If there is a big difference, this will be pointed out. If the clinic has a substantial number of positives in the next age group (20 - 24) and they have a significant number of women tested in that age group, these data might suggest that they consider testing that group routinely, although that has not been common.

Presumptive treatment and clinical signs are main areas of interest in clinical practice. The family planning RAC representative monitors data for indicators of whether the clinic saw patients with Chlamydia risk factors (e.g. Pelvic Inflammatory Disease, mucopus, or contact to Chlamydia) and yet did not provide any presumptive treatment. Comparisons are then made within age groups to see if those women received treatment, and if not, an assessment is made to know if it is a clinical practice issue or documentation issue. The same process is followed for clinical signs: an assessment is made as to whether the clinicians are recognizing the clinical signs or whether the information is not being accurately transferred to the data slips. All this information is written on each report set and sent to the clinic directors.

Following are the schedule of report distribution and the descriptions of data reports now being distributed to project areas:

Jan to Mar data posted to web report for downloading by 5/15

Apr to Jun data posted to web report for downloading by 8/15

July to Sept data posted to web report for downloading by 11/15

Oct to Dec data posted to web report for downloading by 2/15

Data Report 1 (DR1) reports positivity rates by client characteristics and age group. There are two sets one for males and one for females. These are done at the aggregate level of agency type and at the individual agency level.

Data Report 2 (DR2) reports positivity rates by agency and age. This report is a list of agencies within a specified group and the corresponding positivity rates for year to date and specific age group.

Quality Assurance 2 (QA2) reports the number (percent) of bad fields by data item and agency.

Quality Assurance 3 (QA3) reports the agency names, agency IDs, and number of records by agency. This report lists the number of records in the database for each agency within the specified search criteria.

**National Laboratory Consultant:**

**Describe the specific types of technical assistance that the National Laboratory Consultant provided to you, a project area or the region during this budget period. (July 1, 2005 – March 30, 2006).**

The National Laboratory Consultant participated in the Laboratory Services Workgroup calls and provided technical expertise with regard to regional pricing and other pertinent issues addressed by the Lab Services Workgroup.

**National Data Consultant:**

**Describe the specific types of technical assistance that the National Data Consultant provided to you, a project area or the region during this budget period. (July 1, 2005 – March 30, 2006).**

The RAC received extensive training from the Regional Data Consultants during 2004-05 fiscal year. This assistance has provided a foundation upon which the RAC has continued its data activities.

**C. Objectives for New Budget Period - July 1, 2006 - June 30, 2007**

- **Provide measurable, time-phased objectives for each of the following categories: administration, coordination, communication, data management and analysis, and program promotion.**
- **For each objective, provide methods or activities that outline how the objective will be accomplished. Activities should be measurable and specific.**

Measurable, time-phased objectives are provided for each of the following categories: administration, coordination, communication, data management and analysis, and program promotion. For each objective, methods or activities outline how the objective will be accomplished.

**ADMINISTRATION:**

**OBJECTIVE 1:** Prepare and submit infrastructure and regional plans and required reports to CDC by specified due dates, but no later than June 30, 2007.

**METHODS:** a) JSI will respond to the Regional Infertility Prevention Projects Infrastructure Application Guidance and develop a work plan pertinent to the Regional Coordinator Roles and Responsibilities document.

b) JSI will work with the Region VIII RAC to develop a Regional Plan which is responsive to the Infertility Prevention Project Regional Plan Guidance and which will move the Region VIII IP Project ahead in meeting long-term goals stated in the Coordinator's Visioning Document and the DSTDP's Strategic Plan.

c) JSI will prepare and submit any other required reports to CDC and OPA in accordance with the funding Memorandum of Agreement.

## **COORDINATION:**

**OBJECTIVE 2:** Promote the goals and objectives of the project by supporting the planning process for two regional meetings via at least two conference calls conducted by June 30, 2007.

**METHODS:** a) Two RAC meetings will be held during the 2006-07 project year. Meetings are currently slated for spring and fall. Conference calls will be set up for the Executive Committee, Laboratory Subcommittee, and existing workgroups within 10 weeks before the meeting dates to plan the meeting agenda.

b) Arrange for transportation, meeting coordination of information, identification and coordination of consultants for each RAC meeting.

c) Develop draft form documents and distribute the reports within eight weeks after each RAC meeting and within 4 days of conference calls.

**OBJECTIVE 3:** Increase opportunities for communication and collaboration among CDC, JSI, and project areas between July 1, 2006 and June 30, 2007.

**METHODS:** a) As needed, assess the need for technical assistance or site visits to project areas for the following indications: new participating agency, new RAC representative or if a project area and/or clinic is/are experiencing problems with a specific aspect of the project.

b) By June 30, 2007 complete any identified technical assistance/site visit and create a summary of technical assistance/site visit plan within 2 weeks of completion.

**OBJECTIVE 4:** Assist states in implementing at least one prioritized goal from the updated Strategic Plan between July 1, 2006 and June 30, 2007.

**METHODS:** a) Provide logistical support and program guidance to workgroups focusing on at least one goal prioritized in the Strategic Plan reflecting the following priority areas: Effective Use of Resources, Lab Services, and Partner Services/Treatment Verification.

b) Support each state laboratory in obtaining Public Health pricing for tests by gathering information on regional testing volumes and manufacturer volume requirements.

c) Produce data reports and assistance with data analysis to workgroups as needed.

## **COMMUNICATION:**

**OBJECTIVE 5:** Participate in 2-3 national meetings and at least nine IPP Coordinators conference calls on behalf of Region VIII between July 1, 2006 and June 30, 2007.

**METHODS:** a) Attend Chlamydia Coordinators meetings two times per year and participate in monthly conference calls  
b) Attend other national conferences pertaining to Chlamydia, such as the National STD Prevention Conference every other year.  
c) Report pertinent information appropriate to the RAC within 2 weeks of participating in IPP Coordinator conference calls.

**OBJECTIVE 6:** Communicate national and local research activities and results to project partners between July 1, 2006 and June 30, 2007.

**METHODS:** a) Utilize the Region VIII Chlamydia Project website with the primary purpose of acting as a central repository for disseminating ongoing information about the project to its stakeholders as well as the general public.  
b) Continue to provide timely and relevant resources and updates via email, US postal mail, and in person at regional meetings.

### **PREVALENCE MONITORING DATA MANAGEMENT AND ANALYSIS:**

**OBJECTIVE 7:** Submit four complete, accurate and timely prevalence monitoring data file to CDC by June 30, 2007.

**METHODS:** a) Work with Regional Advisory Committee to facilitate monthly delivery of data.  
b) Receive, review and document receipt of monthly data files and forms. Automatically generated email reminders are sent to project areas on the first of each month indicating that data is due in fifteen days. If necessary, follow-up calls are made to project areas to encourage timely submission of data. Project staff will consult with other regional coordinators to assess best practices.  
c) Monitor data quality and consistency as new data are added to the database.  
d) Provide CDC with clean data collected at quarterly intervals. Provide CDC with an updated, comprehensive data file containing all valid data collected during a one-year interval.

**OBJECTIVE 8:** Provide data management to the six primary project areas (the state laboratories) and the five city and county labs in Colorado that provide data directly to the regional database and requested technical assistance to at least five project areas by June 30, 2007.

- METHODS:**
- a) Work with each state on an individual basis to research and report back any discrepancies in the data format or coding structure.
  - b) Communicate data dictionary requirements and resolve issues related to data quality.
  - c) Perform analyses on the data to verify data quality or identify potential problems.

**OBJECTIVE 9:** Provide data entry for four project areas that do not have staff to support keying activities between July 1, 2006 and June 30, 2007.

- METHODS:**
- a) Receive, review and document monthly receipt of lab slips and forms.
  - b) Perform data entry of designated data elements and review quality.
  - c) Organize and securely store lab slips so as to maintain confidentiality.

**OBJECTIVE 10:** Oversee and facilitate requested analyses of regional prevalence monitoring data in order to inform program planning and evaluation efforts between July 1, 2006 and June 30, 2007.

- METHODS:**
- a) By June 30, 2007, document web-based tutorial for accessing and interpreting data reports.
  - b) By June 30, 2007, produce at least one regional analysis such as comparison of positivity rates of males; re-infection rates; or screening criteria adherence.

**OBJECTIVE 11:** Disseminate data within the region between July 1, 2006 and June 30, 2007.

- METHODS:**
- a) By June 30, 2007, produce user-friendly data reports that are accurate, timely and easily transmittable into other applications. All datasets spanning from 1994 to the current data posting are to be available for programs to access for reporting.

**Measures of Effectiveness for New Budget Period: July 1, 2006 – June 30, 2007**

**For the following proposed measures of effectiveness, provide a brief description of the rationale for the measure in your region, a clear reference to your regional plan, as well as possible reporting criteria. Develop brief definitions for each measure's numerator and denominator. Describe available data sources including the quality of the data and the limitations of the data. Discuss possible barriers to addressing each measure, and if implemented, a plan to obtain data in 2007.**

**Measure: Proportion of Family Planning clinics adhering to regional screening criteria.**

**Rationale**

**Strategic References:** Corresponds to Regional Plan Priority Area Effective Use of Resources; HP 2010 goals 25-1: “Reduce the proportion of adolescents and young adults with CT infections” and 25-6: “Reduce the proportion of females who have ever required treatment for PID”; and IOM goal #3: “Design and implement essential STD-related services in innovative ways for adolescents and under served populations.”

**Reference to Regional Plan**

This measure of effectiveness corresponds to the workplan of the Effective Use of Resources Workgroup’s Evaluation Plan:

Goal: Ensure appropriate data collection and use for program planning.

Objective:

To measure adherence to screening criteria which includes that all women under 25 are screened; that all women over 25 are screened if they have a specific risk history or specific clinical symptoms and that there is at least an 80% compliance rate.

**Possible Reporting Criteria**

The analysis results will be reported for a calendar year and aggregated for the region, by each state. Results will be presented at the agency level if at the state aggregate is below the 80% adherence rate.

**Definitions**

*Numerator:* Number of Family Planning Clinics with at least 80% of female patients screened also meeting screening criteria

*Denominator:* Number of Family Planning Clinics

*IPP Family Planning Clinics:* All family planning clinics that report data as part of the DSTDP Chlamydia Prevalence Monitoring Project, regardless of whether they are integrated clinics or not. All women testing positive at integrated clinics should be counted regardless of the type of patient (STD or FP) and source of payment (STD or FP).

**Possible Data Sources, Its Quality and Limitations**

*Data source:* IPP database. All regional projects, in collaboration with state STD control and family planning programs, report their chlamydia positivity data to the regional database (housed at JSI Research & Training Institute in Denver, for Region VIII) which is then forwarded to CDC. For some of the programs in Region VIII, federally -funded programs supplement existing local and state funded testing programs. These publicly funded programs support chlamydia screening primarily in family planning clinics, but also in some STD clinics, jails and juvenile detention centers, Indian Health Service, and other sites. The Public Health Service Region VIII referred to in the data tables are the following: Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming.

FPAR data and other FP clinic administrative data.

*Quality and Limitations:* The interpretation of chlamydia data is compounded by several factors.

- First, case reports and prevalence data result from the use of several different types of diagnostic tests for chlamydia infection (e.g. DNA probe assay, DNA amplification); these tests vary in their sensitivity and specificity.
- Second, chlamydia positivity among women attending clinics is an estimate of prevalence; it is not true prevalence. Crude positivity may include those women who are tested two or more times during a single year. Comparisons of positivity with prevalence have shown that in family planning clinics, positivity is generally similar to or slightly higher than prevalence, and in STD clinics, positivity is somewhat lower than prevalence; however, these differences are usually small, with the relative difference <10%.<sup>2</sup>
- Third, while nearly all family planning clinics perform universal screening of sexually active women <20 years of age, and most clinics do so among women <25 years of age, some selective screening is performed among women 20-24 years of age and some level of screening is frequently performed among women >25 years of age.
- Fourth, while monitoring prevalence among persons seeking care at clinics provides important information on certain segments of the population, these data cannot be generalized to the population as a whole.<sup>1</sup>
- Fifth, the data that are reported into the regional database do not reflect all the screening and testing being performed across PHS Region VIII.
- Lastly, the enhanced data elements (clinical signs and risk history) and gonorrhea data only reflect a certain portion of records reported to the regional database.

#### **Possible Barriers to Addressing this measure**

- 80% adherence may be too low or too high to characterize a site as having met screening criteria.
- Limited to describing the screening that is reported to the Region VIII IPP database.
- Varying screening criteria by state and/or agency.
- Difficulty in merging FPAR or other administrative data.

#### **Plan to obtain data in 2007, if implemented**

The Effective Use of Resources workgroup has established three possible plans for performing this analysis:

##### **Plan A**

1. Find out if FPAR administrative data is available for analysis;
2. Merge and recode chlamydia data and FPAR data;
3. Analyze the above data;

4. Review with epidemiologist.

#### Plan B

1. Analyze chlamydia database;
2. Identify demographic characteristics of clinics and compare with data in chlamydia database.

#### Plan C

1. Conduct QI or chart review on clinic using random sample of patients.

**Measure: Chlamydia screening coverage estimate for 15-19 year old sexually-active women seen in Family Planning clinics.**

#### Rationale

**Strategic References:** Corresponds to Regional Plan Priority Area Effective Use of Resources; HP 2010 goals 25-1: “Reduce the proportion of adolescents and young adults with CT infections” and 25-6: “Reduce the proportion of females who have ever required treatment for PID”; and IOM goal #3: “Design and implement essential STD-related services in innovative ways for adolescents and under served populations.”

#### Reference to Regional Plan

This measure of effectiveness corresponds to the workplan of the Effective Use of Resources Workgroup’s Evaluation Plan:

Goal: Ensure appropriate data collection and use for program planning.

Objective:

To determine the proportion of the sexually active women in the family planning clinic population that is being screened for Chlamydia.

- Out of all women 15 - 19 years old who received services at a Title X FP clinic in a calendar year, what percent received at least 1 chlamydia test?

#### Possible Reporting Criteria

The analysis results will be reported for a calendar year and aggregated for the region, by each state.

#### Definitions

*Numerator:* Number of unduplicated female Family Planning clinic clients who are age 15-19, are documented in their charts as being sexually active, and are screened at least once for Chlamydia during the defined timeframe.

*Denominator:* Number of unduplicated female clients of Family Planning clinic clients who are age 15-19, are documented in their charts as being sexually active during the defined timeframe.

*IPP Family Planning Clinics:* All family planning clinics that report data as part of the DSTDP

Chlamydia Prevalence Monitoring Project, regardless of whether they are integrated clinics or not. All women testing positive at integrated clinics should be counted regardless of the type of patient (STD or FP) and source of payment (STD or FP).

### **Possible Data Sources, Its Quality and Limitations**

*Data source:* IPP database. All regional projects, in collaboration with state STD control and family planning programs, report their chlamydia positivity data to the regional database (housed at JSI Research & Training Institute in Denver, for Region VIII) which is then forwarded to CDC. For some of the programs in Region VIII, federally -funded programs supplement existing local and state funded testing programs. These publicly funded programs support chlamydia screening primarily in family planning clinics, but also in some STD clinics, jails and juvenile detention centers, Indian Health Service, and other sites. The Public Health Service Region VIII referred to in the data tables are the following: Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming.

Chlamydia tests in FP Title X clinics are counted via the IPP data system.

Chlamydia test information is captured via the IPP lab slip.

FPAR Data or other FP clinic administrative data.

*Quality and Limitations:* The interpretation of chlamydia data is compounded by several factors.

- First, case reports and prevalence data result from the use of several different types of diagnostic tests for chlamydia infection (e.g. DNA probe assay, DNA amplification); these tests vary in their sensitivity and specificity.
- Second, chlamydia positivity among women attending clinics is an estimate of prevalence; it is not true prevalence. Crude positivity may include those women who are tested two or more times during a single year. Comparisons of positivity with prevalence have shown that in family planning clinics, positivity is generally similar to or slightly higher than prevalence, and in STD clinics, positivity is somewhat lower than prevalence; however, these differences are usually small, with the relative difference <10%.<sup>2</sup>
- Third, while nearly all family planning clinics perform universal screening of sexually active women <20 years of age, and most clinics do so among women <25 years of age, some selective screening is performed among women 20-24 years of age and some level of screening is frequently performed among women >25 years of age.
- Fourth, while monitoring prevalence among persons seeking care at clinics provides important information on certain segments of the population, these data cannot be generalized to the population as a whole.<sup>1</sup>
- Fifth, the data that are reported into the regional database do not reflect all the screening and testing being performed across PHS Region VIII.
- Lastly, the enhanced data elements (clinical signs and risk history) and gonorrhea data only reflect a certain portion of records reported to the regional database.

### **Possible Barriers to Addressing This Measure**

- Varying methodologies and databases by each FP grantee for collecting administrative data.
- Difficulty in merging FPAR or other administrative data, since in general, CVR and IPP records are independent.
- Limited to describing the screening that is reported to the Region VIII IPP database.

### **Plan to Obtain Data in 2007, if Implemented**

The Effective Use of Resources workgroup has established a two-phase plan for performing this analysis:

1. Use individual-level records in the CVR and IPP data sets to create summary information about each clinic (for example, percent of visits age 15 – 19 in each clinic) and then merge administrative data and IPP clinic-level records.  
Different data sets may yield very different estimates. Initial important questions to ask are: How are clients counted? If IPP data is used, how do you link the separate chlamydia test data with the total client FP visits in an accurate way?
2. Merge and recode chlamydia data and FPAR data;
3. Analyze the above data;
4. Review with epidemiologist.

