

## SUMMARY

### REGION VIII IPP REGIONAL ADVISORY COMMITTEE MEETING MAY 28-29, 2009

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#### 1. Attendance

Attending	Christine Mandl (CO-FP) Kelly Voorhees (CO-STD) Laura Gillim-Ross (CO-Lab) Liz Johnson (MT-FP) Susie Zanto (MT-Lab) Laurie Kops (MT-STD) Mike Trythall (ND-Lab) Sandy Fetzer (ND-FP) Julie Wagendorf (ND-STD) Dave Morgan (SD-STD) Penny Davies (UT-FP) Emily Holmes (UT-STD)	Tom Sharpton (UT-Lab) Jesse Harbour (UT-Lab) Claudia Rogers (WY-Lab) Canyon Hardesty (WY-STD) Jan Andrews (WY-FP) Rick Steece (NCLC) Steven Shapiro (CDC) Scott Tulloch (CDC-IHS) Jill Leslie (FP Reg'I Office) Karen Ford-Manza (AZ FP Council) Mary McCrimmon (JSI) Lori Nichols (JSI)
Absent	Terry Disburg (SD-FP)	

#### 2. Topics Discussed [click on a topic to jump to that section]

- a) [Regional Update](#)
- b) [PCSI, Performance Measures, HEDIS & STD Awareness Campaign](#)
- c) [Private Provider Pilot Update](#)
- d) [State Highlights on Private Provider Outreach and/or Pregnancy Test Visit Initiatives \(UT & ND\)](#)
- e) [How to Define "Private Provider"](#)
- f) [State Highlights on Private Provider Outreach and/or Pregnancy Test Visit Initiatives \(WY & CO\)](#)
- g) [Private/Public Lab Services](#)
- h) [Arizona Pregnancy Test Visit Project](#)
- i) [State Highlights on Private Provider Outreach and/or Pregnancy Test Visit Initiatives \(MT & SD\)](#)
- j) [Family Planning Issues/Trends that Impact Expanding Chlamydia Screening](#)
- k) [Developing Advocacy \(Education\) Strategies And Tools](#)
- l) [Introduction To Gonorrhea Meeting](#)
- m) [Planning for the November Meeting](#)

#### 3. Discussion

- Regional Update - *Lori Nichols, IPP Project Manager, JSI Research and Training Institute - [refer to slides and handouts: Region 8 IPP Background; Regional Plan Overview-Priorities; Special Projects Handout]*
- PCSI, Performance Measures, HEDIS (overview and latest data) & STD Awareness Campaign - *Steven Shapiro, National IPP Coordinator, CDC - [refer to slides 1-13]*

During the PCSI discussion, Penny expressed some frustration over the lack of data sharing among state FP and STD/HIV entities. Canyon described the new program that has been instituted in Wyoming where their PRISM system collects STD/HIV data and that information is now available to FP clinicians. This system has been well received by most, with a few outliers who mistakenly believe it to be a HIPAA violation. Steven suggested Canyon submit an abstract on this program for the next STD Prevention conference in Atlanta, so that other states can learn more about this.

#### STD Awareness Campaign

Steven asked the RAC members to share their experiences were with the STD Awareness Campaign. There was also a brief review of the Region VIII summary of STD Awareness activities, highlighting activities that were conducted in Montana, South Dakota, and Wyoming. Lori requested that any

additional information on STD-Awareness month activities be forwarded to JSI so that the current summary could be updated. Kelly stated that they saw an increase in testing in Colorado, but that no positivity data has been made available yet. Canyon explained that Wyoming has had an intern working over the last year to increase STD and HIV awareness and that once the results are available, she will share that report with the RAC. Liz talked about the testing done by their 4 Planned Parenthood clinics, and that tests were sent to CDD for processing. JSI will follow up on the status of getting that data from CDD for inclusion in the IPP database.

There were several comments that STD Awareness materials should have also been tailored for AI/AN clients. Also, translation of the slang terms/phrases would have been helpful for those unfamiliar with them. In terms of marketing materials, buttons worked well - and more could be provided next time.

Dave commented that while he appreciates the national effort for this project, it's really the local community-based organizations that make it work, not the state health departments. Therefore, it's these CBOs that need the seed money.

#### Performance Measures

Regarding timeliness of treatment for both Ct and GC - among FP sites & STD sites - Region VIII has consistently performed above the 85 percentile, which is better than the national average.

However, more progress needs to be made in improving screening coverage for 15-19 year-old females, which in Region VIII has remained steady at 40% 2005-2008, compared to 50% nationally.

#### HEDIS

The Healthcare Effectiveness Data and Information Set (HEDIS) includes a Ct screening measure. HEDIS data is submitted on an annual basis by commercial and Medicaid plans to the National Committee for Quality Assurance (NCQA). The Ct screening measure is under review for continuation and possible inclusion as a measure used for health plan accreditation. Anecdote: Medicaid plans have consistently done better on this measure than commercial plans nationally. However, for the mountain regions, the opposite is true. Nationally, Title X clinics are doing better than either the commercial or Medicaid plans.

Jill encouraged, and Steven concurred, that each state contact Kazi Ahmed to request their state-specific data. (His contact information was distributed on a separate handout.) There should be no cost involved in obtaining this data.

- Private Provider Pilot Update - *Lori Nichols, IPP Project Manager, JSI Research and Training Institute* - [refer to slides and handout: *Chlamydia & Gonorrhea Screening among Private Providers*]

A committee questioned the "inconsistent use of barrier contraceptives" as an indicator for Ct screening (as recommended in the NCC publication, *Why Screen for Chlamydia?*) because it conflicts with the CDC screening recommendations and essentially encourages universal screening. The committee recommended that further consideration be given to whether or not the NCC publication be used in future mailings.

Regarding the layout of the laminated card, the group suggested that the information may be better utilized in a poster format. This is reinforced by the preliminary evaluation results which indicate that several sites posted the cards in waiting and exam rooms. By posting the information in its current format, half of the information provided was not utilized. A poster format would also allow more space to include state-specific info.

- State Highlights on Private Provider Outreach and/or Pregnancy Test Visit Initiatives (UT & ND)

*Emily Holmes, Utah Dept of Health—STD Program*

Topic: Catch The Answers Ct and GC social marketing campaign. For the first time in a decade, they received state funding for infertility prevention. This program targets 15-29 year-olds, their parents, and their (private) health care providers. They also involved Project Smart in developing a youth survey, which received approximately 400 replies; of which 316 were completed in full. They conducted outreach to their private providers enlisting them to share the information with their patients. In the 3 weeks since the Catch the Answers site was launched, they have received approximately 1400 hits.

The site also provides an opportunity for visitors to ask questions, to which they have received several, some related to Ct/GC, and some related to other STDs and sexual issues. Rick suggested that they consider compiling and sharing their Q&A's with the region, and other regions.

The demographic question portion ("Who Are you?") has not received as good a response rate as the Q&A section. To promote the site, they also developed a flash card and car magnet message campaign that was implemented at a local rock concert, at which they had a booth and handed out the magnets to concert-goers. At the end of the concert, they assumed the campaign to be a success as evidenced by the fact that people did not throw the material in the trash.

The "Provider" page of the website is still a work in progress. This page will include information about EPT, which is especially appropriate because one of the questions they received on the youth page was whether or not people can get treatment without seeing a doctor. One barrier they've found with the providers is they do not want to provide their individual contact information, particularly email address through which they could receive information. An alternate mechanism for getting information into the hands of providers has been to work through a point person (usually an office manager and/or nursing leader) who is willing to receive the materials by email and then forward it to providers. That approach has been more successful.

*Julie Wagendorf, North Dakota DOH*

FP clinics and private providers are the only entities that can/do conduct Ct screening. North Dakota does not have STD clinics. Rates of Ct are highest on the reservations, of which there are 4: 3 are I.H.S. and 1 is tribal health. Recently a nurse educator visited their state to conduct a clinician's training session on the reservation. Contact tracing and partner services is only conducted by state DIS for complicated Ct cases. They rely on the providers to do all non-complicated cases. She gets a lot of questions about when to re-test, as well as regarding rectal/oral swabs and NAAT testing. The lack of funding is a major barrier to their reaching out to private providers.

- Large Group Brainstorming Session: How to Define "Private Provider" - What does 'private provider' mean for each state?
  - SD has I.H.S., and other programs such as FP are the only "public" provider entities that he knows of. In his eyes, all others are "private."
  - Any clinics not receiving public dollars (except Medicaid) = private.
  - What about those that receive a mix of public/private funding? Planned Parenthood is a good example of these; also urban Indian clinics.
  - All about perception and access regardless of setting or funding source. Could include even public health clinics that are not currently doing Ct screening. All who aren't aware/involved.
  - Steven asked why we want to come up with a definition of "private provider" that works for the region as a whole. CDC recommendation is not broken down by type of provider. He also gave as an example the difficulty of determining what FP clinics are.
  - Susie and Lori pointed out that the message would be different to a public or a private provider.
  - The question should really be "How do you engage those providers who are identifying your largest amounts of morbidity?"

- IPP is larger than just what we fund for test kits. CDC is asking IPP partners to now begin getting that message out = IPP as agent of best practices to all.
- Refer to the National Data Codebook for how Private Provider is defined.

**Brainstorming Outcome:** The committee did not reach consensus on defining “Private Provider” and questioned the value of establishing a formal definition, as it may depend on how or what the communication or marketing is trying to achieve/address at any given time.

- State Highlights on Private Provider Outreach and/or Pregnancy Test Visit Initiatives (WY & CO)

*Canyon Hardesty, Wyoming STD*

Wyoming began an outreach program to those clinics in areas with the highest morbidity. Historically in Wyoming STD screening has only been offered at PHN office that also offered family planning services. That means that for about 10 of their counties, the only access to screening is through their private providers or a separate FP clinic, sometimes limited by how many hours or days that screening is available. They are working with some of the private providers to offer additional screening, and while the providers are receptive, there may be concerns about the potential cost to clients. They have been working with the PHN program to establish a standing order for collecting urine samples for Ct/GC screening. None of this has been tied to funding, yet these providers are still willing to continue doing the screening. The program has also included some women’s health sites for PTO clients.

*Kelly Voorhees, Colorado STD - [refer to handout]*

MCPN is a primary care/community health network, an FQHC, and according to the PA there, considered to be the STD champion, they are only doing Ct testing.

- Private/Public Lab Services - *Rick Steece, National Chlamydia Laboratory Coordinator - [refer to slides]*

The most compelling argument for public lab vs. private lab is that a public lab will look for changes in disease incidence and can test populations. To the credit of public health labs, many advances in testing technology have come as a direct result of evaluations and studies done by public labs.

- Arizona Pregnancy Test Visit Project - *Karen Ford Manza, Executive Director, Arizona Family Planning Council - [refer to handout]*
- State Highlights on Private Provider Outreach and/or Pregnancy Test Visit Initiatives (MT & SD)

*Liz Johnson, Montana FP - [refer to slides]*

*Dave Morgan, South Dakota STD*

- 300 GC cases per year; 2700 Ct cases per year
- Over 50% of GC cases are in AI pop; and more than 85% of these come from 6 geographic locations
- Office of Disease Prevention “STD clinics” reported 16% of GC and 12% of Ct cases
- Due to reducing budgets and staff, they are looking at ways to focus more closely on targeting specific populations. However, the good news is that the state has offered some STD-specific funding and will fund 1 FTE. There is also the potential for some additional funding that was unused by another project, but that funding is still pending.

- Family Planning Issues/Trends that Impact Expanding Chlamydia Screening - *Jill Leslie, Public Health Advisor/Regional Program Consultant, Region VIII OPA/OFP, and panel - each state FP program representative*

Jill explained their funding and how it flows to the various projects: Region 8 FP Training & TA, Male Services Special Project (UT, MT, and WY are currently funded), Region 8 RQIP, Region 8 Clinic

Efficiencies, and other discretionary projects. Jill also mentioned that, for the next national clinical training workshop, she is considering including a topic on helping clinicians learn how to properly screen for chlamydia.

Additional FP representatives shared information about the following projects and activities:

*Penny Davies - Utah Male Services Project*

Penny described that 10% of their clinics' total population is male, and it is growing. There are no subsidized services for men. They use the money for the male project for screening males for Ct. She mentioned anecdotally that when they ask male clients about donating a portion of the total cost for their services, they are more generous in the amounts than females.

*Liz Johnson - Male Services Clinician Training*

Liz explained that historically there has been a lot of reluctance by nurses to doing male exams because of lack of confidence in skills. They decided to provide clinician training using live male models (some nursing students, some young men and couple of older men). All clinicians gave positive feedback on the training and were more confident about providing services to men. The training resulted in male exam numbers increasing by 17%. Clinics see the importance of sustaining these services, but if project funding is eliminated, there is uncertainty around how these services will continue to be funded.

*Jan Andrews - Wyoming Male Services Project & FP Expansion Project*

Wyoming sent several clinicians to the clinical training that was held in Denver in the summer of 2008. For 2 yrs, they have sent a few people to the national clinical training, and their state meeting. This year's state meeting will include training on dealing with "abnormal" male exams. They are also using some of the money for testing males for CT. All clinics have completed the male-friendly audit of their facilities. Expansion money is being used to target non-traditional settings for FP services including some adolescent group facilities, and the AI reservation in Fremont Co.

*Sandy Fetzer - North Dakota American Indian Strategic Initiative*

Custer Family Planning in Bismarck opened a clinic at Standing Rock/Ft Yates. The first clinic was set up in December 2008. Things are going well, and they're looking at expanding into some other areas.

*Christine Mandl - Colorado FP Expansion Project*

Denver Health CHC system - 3 of their sites were designated as FP Title X sites. Anyone who visited other sites could be referred to the Title X sites. They've since expanded into 2 more sites. Two sites are teen clinics and one serves primarily Spanish-speaking clients. The sites serve women and men. They also added a site in Grand Junction which is now offering FP services outreach to rural areas.

- Developing Advocacy (Education) Strategies And Tools: (1) Funding advocacy for PTV initiatives, and (2) Private provider outreach/collaboration strategy *[refer to small group notes]*
- Introduction To Gonorrhea Meeting - *Steven Shapiro, CDC - [refer to slides beginning slide 14, and handout: Gonorrhea Meeting Information]*

Why do we care about gonorrhea? Why the need for these regional meetings? It's taken only 7 yrs for *N. gonorrhoeae* to become resistant to ciprofloxacin treatment. The only drug left is cephalosporins and it is now showing signs in certain Asian populations of decreased susceptibility, and recommended treatment doses are increasing. Perhaps most important, there are no new drugs in the pipeline. There is a need to increase screening and intensify partner services in order to have a significant impact on rates. What can be done in a cost-neutral way?

STD program representatives are the intended audience for the regional meetings. With only one regional meeting now completed, CDC is still figuring out the process, as well as the role of each IPP

regional committee. More info about the Region 8 meeting will be forthcoming in the next couple of months, once JSI and CDC begins the planning process.

- Planning for the November Meeting

JSI asked committee members to begin thinking about what they want to get out of this meeting with the AI/AN focus; JSI will be prompting members for their input in July or August. [*Refer to list of ideas from the Data and Lab Work Groups discussions*]