
A G E N D A

National Chlamydia Coalition Provider Education Committee Meeting

Wednesday, November 30, 2011
11:00 a.m.-12:00 p.m. ET

Dial In Information: 877.939.9724, passcode 3833060

Facilitator: Lisa Goldstein, American College of Obstetricians and Gynecologists

Participants:

Heidi Bauer, California State Department of Health
Eileen Beard, College of Nurse Midwifery
Jessica Boyer, National Family Planning and Reproductive Health Association
Christine Brazell, Office of Population Affairs
Gale Burstein, Society for Adolescent Medicine
Shana Cash, Region V Infertility Prevention Project
Susan DeLisle, Partnership for Prevention
Jaclyn Fontanella, Partnership for Prevention
Alyson Kristensen, Partnership for Prevention
Craig Roberts, American College Health Association
Karen Shea, Planned Parenthood Federation
Marla Tobin, Aetna
Alana Ward, Partnership for Prevention
Vanessa White, Office of Population Affairs

1. Attendance and Welcome
 - a. Welcome Alyson Kristensen, Partnership for Prevention
 - i. Alyson worked with NCC during its formation. She is now available to work on a couple of writing projects for the Provider Ed. Committee during the coming year.
2. Review of Minutes from October 12, 2011 meeting – Accepted without changes
3. Brief Update on Networking Project
 - a. Lisa Goldstein has revised the letter being sent from ACOG to leadership after additional input from Provider Ed. Committee. The letter is ready to be sent once the state contact sheets are finalized. Edits of the state sheets are expected to be finalized by 12/2/2011.
 - b. The letter will also be shared with the new participant from the College of Nurse Midwifery to see if this might be something of interest to send to their leadership.
4. Brief Update on Provider Toolkit – update deferred until January meeting

5. Potential 2011-2012 Priorities for Provider Education Committee
 - a. Prior to the meeting, Lisa Goldstein asked committee members to send their top 3 priorities to her. Four items received the majority of votes from those who had sent in responses: 1) developing resources on EPT; 2) updating *Why Screen?*; 3) compiling a provider toolkit; 4) how to normalize screening, especially in communities of high prevalence
 - b. Discussion ensued about the pros and cons of each of these 4 as well as the other projects on the list.
 - i. EPT –CDC and the Prevention Training Centers (PTCs) have quite a few resources on EPT already. In addition, EPT laws are very diverse and state specific making development of a universally applicable and useful tool quite difficult. The operational assistance that is needed requires a clinic or program specific technical assistance approach (i.e. how to develop a tracking system, creating of log books, etc) and the PTCs are now funded to provide this onsite assistance. The biggest barrier to adoption of EPT is really one of reimbursement and this is a policy issue. This was suggested as collaborative project with the Policy and Advocacy Committee. Though EPT is an important expansion of treatment options, the science is not clear that EPT affects re-infection. Therefore increasing screening rates is likely the higher priority. It was suggested that perhaps a clearinghouse of EPT resources would be the more useful.
 - ii. Updating of *Why Screen?* was deemed a very high priority. Concern was expressed about the cost of updating. Alyson is available to draft the revisions and some other resources have been set aside for the project. Whether sufficient resources are available depends on the scope of the revisions. It was suggested that the title of *Why Screen?* be expanded to *Why Screen and Treat?*. This would allow a section on EPT, talking points on taking a sexual history, and how to introduce Chlamydia and other STD testing. It was also suggested that adding links to more clinical tools in the resource section of the document would be beneficial and assist with “one stop shopping” for providers.
 - iii. Provider Toolkit – There has been prior discussion about creating a specific place on the CRE explicitly for providers that would include quantifiable tools. The CRE was created for public access to public awareness materials such as brochures, pamphlets, etc. to target specific populations. Therefore, a partner site would need to be developed to house provider-specific tools. Once it is known what would be in the toolkit, a cost estimate can be done to determine whether this is a feasible project for this year. It is currently not known how many “hits” there have been on the CRE site as this was inadvertently omitted from the web code. However, information on how often *Why Screen?* readers link to various resources included in the guide can be obtained. Since *Why Screen?* was, and continues to be, quite popular, it was suggested that additional links to new and/or updated clinical tools be included in a revision of the resource section. Electronic copies of *Why Screen?* will be disseminated to the committee for review prior to the annual meeting. Hard copies will also be available at the meeting as well.
 - iv. How to normalize screening, especially in communities of high prevalence – there was some confusion about what could/should be developed to

accomplish this. In many ways GYT is about normalizing testing. There may be provider interest in a tool to help introduce chlamydia screening to adolescents; this tool could incorporate aspects of how to introduce Chlamydia and other STD testing as well points on talking points on taking a sexual history. This was suggested as a potential collaborative project with the Public Awareness committee.

- v. Other potential projects
 - 1. Preparing a paper on what it would take to get everyone screened and tested. Discussion on this was deferred until the January meeting.
 - 2. Compile Best Practices and Interventions that work. A review of 17 interventions that examined screening coverage and outcomes has been published. Electronic copies of the article will be disseminated to committee members prior to the annual meeting. Hard copies will also be available at the meeting. Discussion also ensued around caution in using the term “best practices” until there has been sufficient evaluation and review. Use of the term “promising practice” or “evidence-based practice” was suggested.

c. Ultimately the top two priorities for the year are:

- i. Update *Why Screen?(and Treat?)* to include new data, a section on EPT, additional talking points on taking a sexual history, how to introduce Chlamydia and other STD testing, and expanding the number of links for clinical tools in the resource section
- ii. Provider Toolkit – First it needs to be determined what would be in the toolkit. Then a cost estimate can be completed to determine whether it could/should be a partner website to the CRE, or incorporated as web links in other resources.

6. NCC Update

- a. Susan DeLisle let the committee know that a small planning group was convened on November, 14, 2011 to assist with developing a strategic plan for the NCC and provide input on the annual meeting. A meeting summary is being prepared. Members will be asked to provide input to the draft, which will be included in the briefing book, at the annual meeting.

7. Other discussion items? – There were none

8. Next Meeting in Person at NCC Annual Meeting, January 26, 27, 2012